Exhibit No. 18

STATE OF ILLINOIS
COMPREHENSIVE STATE HEALTH PLANNING AGENCY
OFFICE OF THE GOVERNOR
HEALTH SERVICES COORDINATION PROGRAM OF SOUTHERN ILLINOIS
LIFE SCIENCE BUILDING I - ROOM 229
SOUTHERN ILLINOIS UNIVERSITY
CARBONDALE, ILLINOIS 62901
PHONE 618-549-6113
RICHARD B. OGILVIE, GOVERNOR
ALBERT W. SNOKE, M.D., EXECUTIVE DIRECTOR

March 15, 1972

E. J. Gillespie, D. D. S.
320 Ninth Street
Cairo, Illinois 62914

Dear Dr. Gillespie:

As a part of our health planning activities we have collected considerable information relating to available health manpower sources and current need. As a comprehensive health planning organization, we are not only concerned about assisting communities in alleviating their immediate needs.

From the data and information to date, it appears that Alexander and Pulaski counties have acute need for additional physician, dentist, and professional nurse manpower. We have an opportunity to implement the existing manpower in these two counties through assignments from the National Health Service Corp.

In your position as a practicing dentist, we need to know if you concur with the assessment of need and wish to solicit your active participation in the project.

If you do concur, please complete the form provided and add any comments you wish.

Thank you for your interest and cooperation.

Sincerely,

Maxine Rosenbarger

Maxine Rosenbarger, Ph.D.
Director

MR/mrf

495-091 O - 74 - 29

Exhibit No. 19

Southern Illinois District Dental Society

1970 - 1971

COMMITTEES

MEMBERSHIP LIST

1970 - 1971 OFFICERS

DATES OF MEETINGS

July 24, 1970 — Benton ..... Picnic

October 22, 1970 ..... Salem Elks

January 28, 1971 — Marion V. A. Hospital

March 11, 1971 — Carbondale ..... S.I.U.

Exhibit No. 19—Continued

COMMITTEES

Executive

C. L. Friend Jr. – Chairman

Rob't Mick

Bill Lindenberg

W. E. Petty

W. C. Thalman

Nominating

C. L. Friend Jr. – Chairman

Warren Petty

Ethics, Censorship & Judication

Clifford Neill – Chairman

Glenn Ozburn

J. A. Langenfeld

Membership

C. L. Friend Sr. – Chairman

J. R. McIntire

Jerry Hill

Public Relations

Alan Willis – Chairman

George Cavaness

Exhibit No. 19—Continued

Program

Charles White – Chairman

C. L. Friend Jr.

V. A. Beadle Jr.

W. R. Simpson

Dental Health

R. K. Mick – Chairman

John R. Fry

F. G. Choisser

Gary Shaw

Picnic

Warren Petty – Chairman

W. R. Simpson

Louis Smith

Jerry D. Hill

Insurance & Federal Legislation

Robert Dudenbostel – Chairman

John Kaeser

Necrology

V. A. Beadle – Chairman

H. W. Willis

Roy Baldridge

Charles G. White

C. L. Friend Sr.

Exhibit No. 19—Continued

S.I.U. - V.T.I. Liaison

C. L. Friend Jr. – Chairman

George Cavaness

Clifford G. Neill

Warren Petty

J. O. Hudgins

W. C. Thalman

A. L. Lenzini

Joseph M. McAlpin

Civil Defense

R. E. Holloway – Chairman

D. L. Smothers

Ron Darnell

Widows' Aid Committee

Joseph F. Scott – Chairman

Glenn Ozburn

Guy Lambert

Editor

C. L. Friend Jr.

Exhibit No. 19—Continued

MEMBERSHIP LIST

(Alphabetically by Counties)

Alexander

Dr. E. J. Gillespie, Cairo
Dr. William Kobler, Cairo

Fayette

Dr. E. J. Bost, Vandalia
Dr. William E. Stringer, Vandalia
Dr. Charles J. Wills, Vandalia
Dr. Austin M. White, Vandalia
Dr. Howard W. White, Vandalia

Franklin

Dr. A. K. Basso, Christopher
Dr. James M. D'Amico, West Frankfort
Dr. Jerry D. Hill, Benton
Dr. Guy W. Lambert, West Frankfort
Dr. L. W. McBride, Sesser
Dr. Warren E. Petty, Benton
Dr. Richard W. Simpson, Benton
Dr. Lewis Smith, Benton
Dr. Earl A. Woods, West Frankfort
Dr. C. W. Elder, Benton

Gallatin

Dr. F. G. Choisser, Shawneetown

Hamilton

Dr. M. W. Carlton, McLeansboro
Dr. C. R. Winfree, McLeansboro
Dr. R. D. Hall, McLeansboro

Hardin

Dr. W. H. Birch, Rosiclare
Dr. Larry Douglas, Rosiclare

Jackson

Dr. V. A. Beadle Jr., Carbondale
Dr. V. A. Beadle, Carbondale
Dr. C. E. Birkner, Murphysboro

Exhibit No. 19—Continued

Dr. Tracy Bryant, Carbondale
Dr. George Cavaness, Carbondale
Dr. Victor De Frank, Carbondale
Dr. Robert Dudenbostel, Carbondale
Dr. C. L. Friend, Carbondale
Dr. John R. Fry, Murphysboro
Dr. John O. Hudgins Jr., Murphysboro
Dr. George Karnes, Carbondale
Dr. L. R. Mittendorf, Murphysboro
Dr. Clifford G. Neill, Carbondale
Dr. Fred Nolen, Carbondale
Dr. H. L. O'Connell, Murphysboro
Dr. Glenn Ozburn, Murphysboro
Dr. Lyle D. Perry, Murphysboro
Dr. Charles Reel, Carbondale
Dr. E. R. Rosenberger, Murphysboro
Dr. Terry Thalman, Carbondale
Dr. W. C. Thalman, Carbondale
Dr. W. E. Wagner, Ava
Dr. Allen Willis, Carbondale
Dr. H. W. Willis, Murphysboro

Jefferson

Dr. J. J. Corlew, Mt. Vernon
Dr. Allen D. Fry, Mt. Vernon
Dr. M. M. Lumbattis, Mt. Vernon
Dr. William N. McAtee, Mt. Vernon
Dr. D. J. McCullough, Mt. Vernon
Dr. Roy G. Miller, Mt. Vernon
Dr. E. E. Neal, Mt. Vernon
Dr. Bert W. Schmitt, Mt. Vernon
Dr. Jack J. Setzekorn, Mt. Vernon
Dr. J. W. Setzekorn, Mt. Vernon
Dr. W. E. Setzekorn, Mt. Vernon
Dr. George W. Waters, Mt. Vernon
Dr. R. H. Whitaker, Mt. Vernon

Johnson

Dr. Royce S. Hundley, Vienna
Dr. C. R. Moschenross, Vienna

Marion

Dr. Roy Baldridge, Centralia
Dr. Richard C. Baldwin, Centralia
Dr. Richard D. Bazzetta, Salem
Dr. Charles Brink, Centralia
Dr. Eugene Clarke, Centralia
Dr. C. S. Gillison, Centralia

Exhibit No. 19—Continued

Dr. C. F. Hampton, Salem
Dr. E. O. Hancock, Salem
Dr. Roy F. Kasten, Centralia
Dr. Ben Keller, Centralia
Dr. J. A. Langenfeld, Centralia
Dr. Wayne Larson, Salem
Dr. W. H. Lindenberg, Centralia
Dr. Richard P. Lugullo, Centralia
Dr. Kenneth D. McCall Jr., Centralia
Dr. Robert McGordon, Salem
Dr. Gerhard Melcharek, Centralia
Dr. R. K. Mick, Centralia
Dr. W. E. Van Horn, Salem
Dr. Michael Zibby, Centralia

Massac

Dr. M. D. Dixon, Metropolis
Dr. C. L. Friend Jr., Metropolis
Dr. Joseph F. Scott, Metropolis

Perry

Dr. C. M. Benton, Du Quoin
Dr. C. E. Boyles, Du Quoin
Dr. Herbert Chapman, Pinckneyville
Dr. W. E. Leach, Du Quoin
Dr. Sam S. Marshall, Tamaroa
Dr. J. R. McIntire, Du Quoin

Pope

Dr. S. K. Barger, Golconda

Pulaski

Dr. James M. Turner, Grand Chain

Saline

Dr. Ron Darnell, Harrisburg
Dr. C. W. Elder, Harrisburg
Dr. B. B. Funkhouser, Harrisburg
Dr. James W. Gaskins, Harrisburg
Dr. John L. Hodge, Eldorado
Dr. W. F. Johnson, Eldorado
Dr. R. E. "Bob" Pulliam, Harrisburg
Dr. Charles Seten Jr., Harrisburg
Dr. C. S. Taylor, Harrisburg
Dr. Charles C. White, Eldorado

Exhibit No. 19—Continued

Union

Dr. Wm. R. Braun, Anna
Dr. Howard R. Casper, Anna
Dr. H. R. Davis, Jonesboro
Dr. E. O. Johnson, Anna
Dr. Kent K. Kelly, Anna
Dr. Harry B. Shafer, Anna
Dr. John O. Wells, Anna

Williamson

Dr. Eleanor Bushee, S.I.U. - V.T.I.
Dr. W. M. Cain, Marion
Dr. James Dehm, U. S. Penitentiary
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Dr. R. D. Gordon, Creal Springs
Dr. Ray E. Holloway, Herrin
Dr. Leslie E. Jones, Herrin
Dr. John Kaeser, Marion
Dr. L. E. Keller, Marion
Dr. K. K. Kendrick, Carterville
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Dr. E. L. Lyday, Herrin
Dr. H. R. Manfredini, Herrin
Dr. Wm. Masselink, V. A. Hospital, Marion
Dr. Joseph M. McAlpin, Marion
Dr. E. E. Miles, Herrin
Dr. R. E. Owens, Herrin
Dr. J. N. Scudder, V. A Hospital, Marion
Dr. M. A. Shively, Carterville
Dr. D. L. Smothers, Marion
Dr. David P. Travis, Herrin
Dr. W. E. Williams, Marion

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Dr. S. E. Dudley, 7647 15th Avenue North,
St. Petersburg, Florida

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BILL LINDENBERG ..... President-Elect
ROBERT MICK ..... Vice President
WARREN PETTY ..... Secretary-Treasurer

Exhibit No. 20

ST. MARY'S HOSPITAL

CAIRO, ILLINOIS

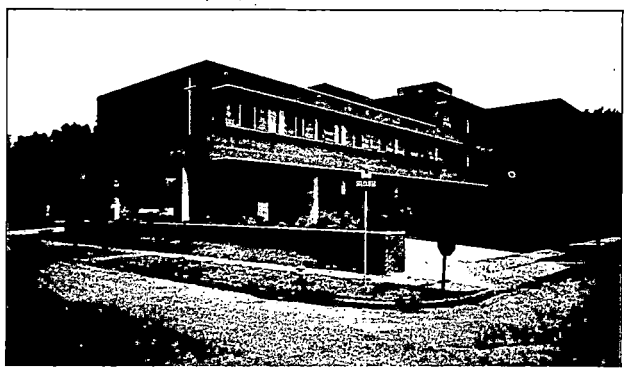
JULY 1969

ANTHONY J. J. ROURKE, INC.

HOSPITAL CONSULTANTS

NEW ROCHELLE, NEW YORK

Exhibit No. 20—Continued



SAINT MARY'S HOSPITAL

Cairo, Illinois

Exhibit No. 20—Continued

SMC

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SMC

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ANTHONY J. J. ROURKE, INC.

HOSPITAL CONSULTANTS

25 OVERLOOK CIRCLE
NEW ROCHELLE, NEW YORK 10804
914 636-8668

July 14, 1969

Sister M. Michaeleen, C. S. C.
Regional Superior
Health Services Region
5401 Seventeenth Avenue Parkway
Denver, Colorado 80220

Dear Sister Michaeleen:

In accordance with our contract with the Sisters of the Holy Cross, Health Services Region, under whose auspices we have been retained as hospital consultants, we submit herewith the report of our findings and recommendations for the long-range development of St. Mary's Hospital, Cairo, Illinois.

This report contains a comprehensive long-range plan for the hospital as well as the basic data and analysis utilized in developing our planning concepts. In essence, these concepts call for continuation of the hospital's historic role in the community, the implementation of new programs and a broadening of the scope of others.

The program we present is extensive and we also realize that a substantial amount of capital will be needed to undertake it. Therefore, all planning must proceed with considerable care. These, though, are the requisites for an up-to-date and dynamic medical care program.

With this report goes our sincere appreciation for the fine cooperation and hospitality extended by everyone involved in the study. To name each person who assisted us would be an impossible task. We sincerely hope that our report will be a valuable aid in your future development.

Sincerely yours,

ANTHONY J. J. ROURKE, INC.
Hospital Consultants

Anthony J. J. Rourke, M.D.
Chairman of the Board

AJJR:pi

Exhibit No. 20—Continued

ANTHONY J. J. ROURKE, INC.

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Bernard Lee
Philip A. Sacco, Jr., Accountant
Helen Shapiro, B. S., M. A.
Lucille Talaska
Charlene W. Vairo

ILLUSTRATIONS AND DRAFTING

Inge Lutze
Carl Mercurio
Anthony J. Monteleone

Exhibit No. 20—Continued

SMC

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Sister M. Gerald Hartney, C. S. C.	Secretary-Treasurer
Sister M. Davida McKenna, C. S. C.	Director
Sister M. Michaeleen Frieders, C. S. C.	Director
Sister Olivia Marie Hutcheson, C. S. C.	Director
Sister M. Rosine Hammett, C. S. C.	Director

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Mr. E. M. Rolwing
Mr. Larry Shoulders

Administrator

Sister Joan Marie, C. S. C.

Exhibit No. 20—Continued

SMC R1

RECOMMENDATIONS

General Planning

1. Master plan St. Mary's Hospital in accordance with the following concepts:

a. Recognition that our analysis of bed need indicates that the total number of beds currently provided by the hospital will be essentially adequate to meet future needs of its service area. Therefore, our program basically involves replacement of nonconforming beds.

b. The need to expand, remodel and/or relocate all existing non-bed areas, except the operating and recovery suite and the labor and delivery suite, in order to provide for needed space and more satisfactory functional relationships.

c. The medical needs of the hospital service area's aged population indicate that St. Mary's should expand its role to provide a more comprehensive approach in areas other than those offered by the traditional acute short-term hospital and implement an extended care program, and a physical medicine service while continuing to offer long-term care.

d. The need to obtain from the city of Cairo approval to close that section of Cross Street which runs from Cedar and Walnut Streets, so that the physical requirements of our proposals can be implemented.

e. Centralization of local health agencies and services at the hospital site.

f. Inclusion of a physicians office building on the hospital site if interest in such a facility is demonstrated.

g. The growing trend of Catholic health care facilities to appoint local representatives to their governing boards, in order that the total community's health care needs can be more effectively expressed and met.

Exhibit No. 20—Continued

SMC R2

2. Consider the substantial impact of these recommendations; therefore, undertake programing in an orderly manner by agreement among members of the governing board, the medical staff, and administration.

3. Take steps to implement a logical building program after studying our findings and recommendations. Also, weigh requests for new development as to their concurrence with the accepted master plan and reject those proposals which do not conform to long-range goals.

4. Provide a master financing plan for long-range capital improvements programs, assuming responsibility for completion of as many major recommendations as possible.

5. Periodically reevaluate any master plan in accordance with changing community health needs.

6. Consider the following bed distribution to meet your hospital's needs by 1975:

Planned Bed Complement: 1975

Service	Beds
Medicine-Surgery	51
Medicine-Surgery and/or Extended Care	24
Pediatrics	10
Obstetrics	8
Subtotal	93
Long-term Care	26
Total	119

Building Planning

7. Consider the Appendix Exhibits as a pictorial translation of our specific recommendations for the future development of St. Mary's Hospital, while recognizing that adjustments in departmental sizes may be necessary as the program develops.

Exhibit No. 20—Continued

SMC R3

8. Proceed with your building development by constructing the following wings and additions to the present hospital complex, and remodeling the nurses home (Appendix, Exhibits 1-6).

9. Southwest Wing - Construct this wing to the southwest section of the 1953 structure, with a basement and three floors and space allocated as follows (Appendix, Exhibits 2-5):

Floor	Function
Basement	Central stores.
First	Radiology and part of administration.
Second	22 beds - expansion of current medical-surgical unit.
Third	18 beds - section of proposed medical-surgical and/or extended care unit.

10. Southeast Wing - Construct this wing to the southeast section of the 1953 structure. This location is based on the premise that Cross Street can be closed from Walnut Street to Cedar Street. As with the southwest wing, the southeast wing should be constructed with a basement and three floors and with space allocated as follows (Appendix, Exhibits 2-5):

Floor	Function
Basement	Maintenance shops and mechanical.
First	Administration.
Second	16 beds - expansion of current medical-surgical unit.
Third	10 beds - pediatrics.

11. Third-Floor Addition - Enclose the roof portion of the south section of the third floor in the 1953 structure. This will afford the needed space for our proposed medical-surgical and/or extended care unit (Appendix, Exhibit 5).

Exhibit No. 20—Continued

SMC R4

12. North Addition - Construct an addition to the north section of the 1953 structure at its basement and first-floor levels only. We have provided an elevator in this addition so that goods brought to the receiving platform, which we have included at the first-floor level, can easily be transported to the basement where central stores is located. Also, on the first-floor level of this addition we have allocated area for dietary storage.

13. West Addition - Construct an addition to the west section of the 1953 structure at its basement and first-floor levels only. We have allocated space at the basement level for housekeeping and linen, expansion of central personnel facilities, and expansion at the first-floor level of outpatient care facilities and the dining area.

14. Remodeling of Nurses Home - Remodel the second floor of the nurses home so that it can accommodate a 26-bed long-term care unit. Also, construct an elevator shaft from our proposed tunnel (as mentioned below) to the second floor of the northwest section of this building. (This remodeling project is contingent on relocation of the Sisters' living quarters which do not have to be on the present hospital site. We do note, however, that another floor could be added to the nurses home.)

15. Construct an enclosed tunnel to protrude above grade; this will necessitate the closing of Cross Street between Walnut and Cedar Streets from the northeast section of the present 1953 structure to the northwest section of the nurses home.

16. Proceed with the expansion and relocation of departments, services, and facilities as follows (Appendix, Exhibits 2-6)...

17. Administration - Expand administration as illustrated in our proposed southwest and southeast wings of the 1953 structure.

18. Pathology - Expand pathology into the area now utilized by radiology.

19. Radiology - Relocate radiology as shown in our proposed southwest wing of the 1953 structure.

20. Physical Medicine and Special Services - Implement a physical medicine program and use as a base for its operations a portion of the area in the basement of the 1953 structure which is

Exhibit No. 20—Continued

SMC R5

currently utilized by central stores. Also, integrate a special services program into the pathology department's functions, for more efficient and effective staffing and supervision. It should be located contiguous to pathology in the area now used by radiology.

21. Outpatient Care Facilities - Expand the present outpatient care facilities to our proposed west addition to the 1953 structure, and into the adjacent area to the north which is currently allocated to administration.

22. Operating and Recovery Suite - We propose no major alterations to this area since it is basically adequate.

23. Labor and Delivery Suite - We propose no major alterations to this suite either, since it is basically adequate.

24. Nursing Units -

1953 Structure and Proposed
Southeast and Southwest Wings of the Structure

Floor	Function
Second	51 beds - medicine and surgery.
Third	8 beds - obstetrics; 10 beds - pediatrics; 24 beds - medicine and surgery and/or extended care.

Nurses Home

Floor	Function
Second	26 long-term care beds.

25. Newborn Nurseries - Remodel the present full-term nurseries so that the suspect nursery can be integrated into this area. Allocate area currently used by the suspect nursery to the 24-bed nursing unit.

26. Central Supply Department - Expand the central supply department into corridor No. 8 (as designated by the floor plans of the hospital as rendered by Long and Underwood, Architects), and the three patient rooms off this corridor which are also opposite the department.

Exhibit No. 20—Continued

SMC R6

27. Pharmacy - Relocate the pharmacy to that area in central stores in the basement of the 1953 structure which is to the east of the elevator shaft.

28. Dietetics - Maintain the current main kitchen but relocate the dietary storage area directly opposite the service elevator in the basement of the 1953 structure to our proposed north addition to the 1953 structure. Also, relocate employee dining facilities to the area currently allocated to the chapel. Expand this area by utilizing that portion of corridor No. 6 (as designated in the above-mentioned set of floor plans) which now separates the chapel from the dishwashing area of the main kitchen and to that portion of our proposed west addition to the 1953 structure which is adjacent to the present chapel.

29. Laundry, Linen and Housekeeping - Maintain the current laundry but relocate linen and housekeeping to be adjacent to it, as shown in our proposed west addition.

30. Purchasing, Central Stores and Storage - Relocate these areas to the basement level of our proposed southwest wing of the 1953 structure. Also, relocate the receiving entrance to the first-floor level of the north addition to the 1953 structure. (As stated earlier, this addition is to contain an elevator which will provide easy movement of goods from the receiving platform to the basement.)

31. Physical Plant and Maintenance - Maintain the present boiler plant but relocate maintenance shops to the basement level of our proposed southeast addition to the 1953 structure.

32. Central Personnel Facilities - Maintain the current central personnel facilities which are in the basement of the 1953 structure but relocate those in the 1923 structure to a portion of the basement level of our proposed west addition.

33. On-Call Rooms - Replace the present on-call facilities with a room on the third floor of the 1953 structure.

34. Remove the 1923 structure and the Maintenance Building.

Site Plan

35. Retain the present main entrance but relocate the dietary and general receiving entrances to the first-floor level of our proposed north addition to the 1953 structure. Also, relocate the emergency entrance to the first-floor level of our proposed west addition in the area allocated for the expansion of outpatient care facilities.

Exhibit No. 20—Continued

SMC R7

36. Provide a minimum of one and one-quarter parking spaces per acute care bed and one space for every two extended care beds in that area vacated by the removal of the 1923 structure and the Maintenance Building.

Other Planning Factors

37. Commit yourself to an acute short-term inpatient care program to the degree described in the findings.

38. Institute a viable home care program and accept, if feasible, the concept of coordinating this program with the visiting nurse services of the Public Health Department or other community-oriented health services; but consider the benefits of basing such a program at the hospital (by the assignment of some personnel there), a continuity of interest, and medical administrative supervision.

39. Implement an extended care program. Consider this to be a dynamic program with the accent on rehabilitation and discharge to the community. Also, consider the advantages which will accrue to a general hospital with accommodations to:

a. Facilitate the normal flow of patients in accordance with medical need.

b. Prevent congestion which could well develop in acute care areas with a sudden influx of those patients who could be satisfactorily cared for in an extended care accommodation.

c. Provide the continuity of patient care which will provide extension of treatment beyond acute care levels in a general hospital environment, with an immediate availability of physician, nursing and paramedical services.

40. Restrict the extended care services to those patients who require regular nursing care under the general supervision of a physician. Also, recognize that rate differentials and cost structures must be firmly established and understood.

Exhibit No. 20—Continued

SMC R8

41. Provide an adequate program of physical medicine, particularly in relation to an extended care program.

42. Support the local mental health and health agencies and services; coordinate your planning objectives with theirs in order to avoid duplication of efforts.

43. Maintain your policy of affording space for these agencies and services at the hospital site.

44. Discuss with your medical staff the potential development of a physicians office building, referring to the advantages of physician-hospital proximity and not-for-profit sponsorship as described in the findings. Also:

a. Initiate this program by developing preliminary sketch plans and, if there is an expressed interest by enough physicians to make the project feasible, proceed with working drawings and build.

b. Accept as a fundamental precept that financing will be on a self-amortizing basis.

c. In the interest of avoiding public misunderstanding, plan this project so that it will not coincide with any solicitation of funds for the hospital's development.

45. Recognize the need to implement a viable, selective physician recruitment program.

46. Move toward broadening the local community's role in the development and operation of St. Mary's Hospital. Retain, though, the right to select and appoint your own auditor and the right to buy and/or sell property.

47. Utilize the findings as a checklist in the review of detailed planning concepts to be considered in your future planning.

48. Retain the services of a qualified hospital consultant to work for you with the architect of your choice in the detailed planning of the proposed physical plant development.

Exhibit No. 20—Continued

SMC 1-1

FINDINGS

GENERAL PLANNING AND UTILIZATION

Introduction

1. Changes are occurring both within the hospital field and the methods of delivery of health care in areas such as Cairo. Any long-range master plan for the future of St. Mary's Hospital must reflect and be responsive to these shifts even though some of them may currently be rather obscure.

2. The planning focus must include short-range and immediate needs of the single agency; however, there must also be an awareness of the total health needs of the citizens of a given area and the framework within which quality service can be offered in the most effective and efficient manner. Therefore, our evaluation mechanisms must be designed to consider both factors.

3. In order to provide a guide for the scope and aim of this study, the major reference points of the contract between hospital and consultant are listed. These include:

a. Determination of the hospital service area, its present population, utilization rates, and forecasts for the next fifteen years.

b. A study of the hospital's activity – past, present and as forecast for the future – as it is related to the community's past and present needs.

c. A study of the departmental areas occupied by each of the hospital activities to determine adequacy of space and functional location.

d. A study of the assignment and use of space within each department or activity.

e. A long-range plan for the future, considering present and future needs and indicating how the hospital can best meet the health needs of the community.

Exhibit No. 20—Continued

SMC 1-2

4. With these initial comments we proceed to analyze the trends of activity at St. Mary's Hospital and to project a program for its future.

Delineation of Hospital Service Area

5. The initial step in determining the future bed needs of St. Mary's Hospital is delineation of the geographical area it serves. For this purpose, an analysis of the residence of patients discharged from the hospital for 1968 was done. By grouping discharges according to precincts in Illinois and townships in Missouri, two distinct areas from which the hospital drew 88.7% of its discharges during the study period were defined. The area having the greatest number of discharged patients accounts for 67% of the total number of discharges. This area, referred to as the primary area, includes the precincts of Cairo, Mounds, Mound City, America Cache No. 1, Cache No. 2, Olmsted, Pulaski, and Villa Ridge – all in Illinois. A primary area, in general, is geographically cohesive in that its patients and physicians associate primarily with the area hospital.

6. The pattern becomes more diffused in the secondary area which utilizes the hospital less actively. At St. Mary's, the secondary area accounts for 21.7% of the discharges; this area includes: the precincts of Grand Chain, Olive Branch, Sandusky, Tamms, Thebes, Ullin, Santa Fe, Miller and Unity in Illinois; and the townships of Ohio, St. James, and Tywappity in Missouri. The inclusion of these townships in the hospital service area is essentially due to the fact that two of the hospital's active physicians practice in Charleston, Missouri. Discharges from outside these defined areas amounted to 11.3%.

7. The primary area had an estimated population of 17,200 in 1968 with an admission rate of 75.1 admissions per 1,000 population. (Note: Because of the insignificant variation between admissions and discharges, we refer to the rate as admissions per 1,000 population to permit a continuity in our usage of terms and comparative analyses in the report.) The secondary area's estimated population was 20,800, with a lower admission rate of 20.1 per 1,000 population.

Exhibit No. 20—Continued

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8. The use of a primary and secondary admission rate enables us to introduce the concept of a weighted hospital service area population. As was stated, the admission rate of the primary service area is 75.1 per 1,000 population. We consider the total population of this area dependent on the hospital. The admission rate of the secondary area is only 20.1 per 1,000 population, showing that only a segment of its population regularly utilizes the hospital. By relating the admission rate of the secondary area to that of the primary area and applying the percentage obtained to the population of the secondary area, we are able to estimate the total weighted population which comprises the weighted hospital service area. For 1968 we estimate the weighted population served by St. Mary's Hospital as 22,800 and the corresponding admission rate as 84.5 per 1,000 population. This is represented geographically in Appendix, Chart 1, and is documented in Appendix, Table 1. This rate is low compared to the national rate of approximately 140 admissions per 1,000 population. While we will discuss the cause of this substantial variation in a later portion of this report, we note here that the local rate indicates a conservative approach to planning.

9. We point out also that this planning analysis involves findings from a single study. Outside influences may modify some of these patterns, and we suggest a periodic reassessment of our basic theses to make sure that their conclusions remain valid. However, these delineated areas are clearly defined and they provide a base on which we can project with relative security, in terms of our planning purposes.

Hospital Service Area Population

10. With the weighted hospital service area defined, we turn now to an analysis of its population from 1940 to 1985 using the United States Bureau of the Census figures for the years 1940, 1950 and 1960. The 1968 estimate and the future projections of the weighted hospital service area's population residing in Illinois are based on figures supplied by the Delta Regional Planning Commission. Past trends were used to base comparable population projections for those townships in Missouri included in the service area.

11. The results of this population analysis are as follows (Appendix, Table 2, Chart 2):

Exhibit No. 20—Continued

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Population and Population Projections for the Weighted Hospital Service Area

Year	Population
1940	32,593
1950	29,476
1960	24,076
1968	22,800
1970	22,900
1975	23,900
1980	26,000
1985	31,700

12. The above table shows that the population of the weighted hospital service area has steadily declined since 1940. This decline is described in a report to the Delta Regional Planning Commission (D. R. P. C.) as being related to ". . . the economic decline of southern Illinois. However, the most significant trend which has taken place in the region of southern Illinois, western Kentucky, and southeastern Missouri is the shifting of population from rural areas to urban areas. This transition in population is the result of changes in agricultural production, consolidation of farms, and better community services." The report goes on to state that even though the Delta area has experienced a decline in population it "... is surrounded by cities that have experienced economic growth and population increases, such as Metropolis and Jonesboro, Illinois; Charleston and Cape Girardeau, Missouri. This is an indication that there are growth potentials within the area which evidently have not been explored as yet."

13. Referring again to the above table, note that the population projections begin to stabilize around 1970 and then actually increase from that point to the last year for which we have made projections – 1985. The report to the D. R. P. C. suggests that this pattern can be anticipated since ". . . future economic developments . . . and new programs being issued by the federal and state governments, which include grants for open space and recreation, highway beautification and programs of the Office of Economic Opportunity, will have a definite impact on the growth of the area. Future development of the Ohio and Mississippi Rivers as natural resources, including the recreational potentials of the rivers and the industrial potentials of the river valleys, will begin to have a major impact on the area . . . Recreational and industrial development within the Delta area will be significant in the encouragement of future population increases and will accentuate the influence of regional factors."

Exhibit No. 20—Continued

SMC 1-5

14. The anticipated increase in population will not be an automatic occurrence but rather the result of an active planning process. This is recognized by the D. R. P. C. which has premised the growth of the Delta area on the following basic assumptions as stated in A Comprehensive Long-Range Development Plan, Delta Region, Illinois:

"1. The high-lift dam proposed to be constructed on the Ohio River will be located in the vicinity of Mound City.

"2. Interstate Route 57 will be completed between Chicago and Interstate Route 55 by 1972. Interstate Route 55 between St. Louis and Memphis will be completed by 1972 and Interstate Route 24 between Interstate Route 57 and Paducah-Nashville will be constructed by no later than 1975.

"3. Major industrial development will be attracted to the American Industrial site with smaller supporting industries locating in the communities and other areas of the Delta area.

"4. Industrial and related development within the general region (West Virginia Pulp and Paper Company, paper plant at Wickliffe, Kentucky; Proctor and Gamble, paper products plant at Cape Girardeau, Missouri; Noranda Mines and Mfg., Ltd., Aluminum Refining plant, at New Madrid, Missouri; and developments in the areas of Carbondale, Illinois, Paducah, Kentucky, and Sikeston, Missouri) will tend to improve the industrial potential of the Delta area as well as improving its status as a place to live and shop.

"5. Recreational developments at Kentucky Lake, Barkley Lake, Rend Lake, and along the Ohio and Mississippi Rivers will tend to improve the potential of the area.

"6. Historic attractions in Cairo and in the general area will be developed and along with more complete development in the Shawnee Hills, Horseshoe Lake and Point Defiance State Park, the tourism potential of the area will be firmly established.

Exhibit No. 20—Continued

"7. Area communities and the two counties will provide the full range of municipal services and utilities and will strive to bring about an upgrading of housing conditions and improvements to business areas.

"8. Scenic routes through the area such as the Great River Road, Lincoln Heritage Trail, George Rogers Clark Recreationway (Mississippi River to Ohio River route through the Union, Johnson, Pope, and Hardin County areas) as well as other scenic roads through the Shawnee Hills area and along the Ohio River will be fully developed by 1985.

"9. The Cairo Central Business District will be redeveloped as an attractive shopping area improving the image of the area as a place to shop.

"10. Highway commercial areas adjacent to the interchanges on Interstate Route 57 and other major highway intersections will be carefully controlled and limited to highway oriented businesses in order to strengthen community business districts.

"11. Housing conditions in the area will be improved through the direct enforcement of codes and ordinances and redevelopment programs."

15. Thus we see that the future outlook for the Delta area, which encompasses much of the hospital service area, points towards a level of optimism. It is conceivable, however, that downward adjustments could occur. The point is that planning must be subject to periodic review; as trends and assumptions change, so too must the conclusions which have been based on them.

16. Besides analyzing the population, it is helpful in planning to also analyze as many of that population's components as affect the utilization of the hospital and which can be measured. It is for this reason that we study the age grouping of the population.

17. Past experience has shown that older age groups use hospital services to a greater extent and maintain longer stays than do younger groups. Also, older populations have a higher occurrence of chronic disease and a greater need for long-term care facilities. This is supported by the following table based on data from the Department of Health, Education and Welfare publication, "Medical Care,

Exhibit No. 20—Continued

SMC 1-7

Health Status and Family Income," which included a documentation of the rate of hospital utilization by age on a national basis for the twelve-month period ending in 1963. This, coupled with similar data for the 1958-60 period, provided an initial base for our study. Adjustments were then made to exclude obstetrical admissions and to focus on the changes in medical-surgical activity.

18. Not only does the H. E. W. study show a substantial variation in medical-surgical admission rates by age category but the rate change shows an increase from the first study period to the second (Appendix, Chart 3):

Patient Admission Ratio Per 1,000 Population

	National Admissions Per 1,000 Population		
	1958-60	1963	Increase
Total	89.8	100.8	11.0
Under 15 years	62.9	65.3	2.4
15 - 44 years	85.6	93.7	8.1
45 - 64 years	115.6	138.8	23.2
65 years & over	145.6	169.9	24.3

19. Evidence of varying lengths of stay by age is also shown as follows:

Percent Distribution of Hospitalized Persons by Length of Stay for Age Groups

	Length of Stay				
Age Group	All Days	1-3 Days	4-7 Days	8-14 Days	15+ Days
Total	100.0%	34.6%	36.2%	18.1%	11.1%
Under 15 years	100.0	54.3	28.7	10.4	6.6
15 - 44 years	100.0	37.8	42.7	14.4	5.1
45 - 64 years	100.0	25.0	31.8	25.3	17.9
65 years & over	100.0	14.6	29.0	29.4	27.0

Exhibit No. 20—Continued

SMC 1-8

20. These findings can be applied to your situation since the proportion of older people in your service area, although only slightly lower than that of the Delta area, is higher than that found in the state and the nation. This is illustrated in the following table (Appendix, Table 3):

Population Distribution by Age: 1960

	Hospital Service Area	Delta Area	Illinois	United States
Total	100.0%	100.0%	100.0%	100.0%
Under 15 years	31.0	29.8	29.8	31.1
15 - 44 years	30.8	31.1	39.0	39.6
45 - 64 years	23.1	23.8	21.5	20.1
65 years & over	15.1	15.3	9.7	9.2

21. The report referred to earlier (A Comprehensive Long-Range Development Plan, Delta Region, Illinois) notes that between 1950 and 1960 the 15-44 year age group (which contains the major portion of the childbearing segment of the population) declined, with substantial losses in the 25-39 year age group. On the other hand, the 65 year-and-over group increased with the 70 year-and-over group showing significant growth. This is a typical trend in an area with a limited economic base; younger people migrate to urban areas to find better jobs, and the older citizens who are less dependent on the economic condition of the community remain.

22. As a result of the population shifts between 1950 and 1960 we see, as indicated in the above table, that the hospital service area's under-15 and 45 - 64 year age groups do not differ greatly from the other areas they are compared to. But the 15-44 year group, while somewhat below the similar group in the Delta area, is significantly lower than this group's total for Illinois and the nation. Conversely, while the 65-year - and - over group approximates that of the Delta area, it is significantly greater than that for Illinois and the nation.

Exhibit No. 20—Continued

SMC 1-9

23. As for the future, the D. R. P. C. anticipates that the revitalization of the area will lead to an increase in the 15-44 year age group.

Inpatient Utilization

24. An analysis of the hospital's inpatient utilization was made for the period 1960-68. The following summary of acute care services indicates that although there was an increase in the average stay and to a degree the percent occupancy, there were decreases in acute care beds, discharges, and the average census for this period (Appendix, Table 4, Charts 4-6):

Summary of Acute Care Inpatient Utilization
1960 - 1968

	1960	1968	Percent Change
Beds	125	98	-21.6%
Discharges	3,152	1,927	-38.9
Average Census	60.9	48.6	-20.2
Average Stay	7.1	9.2	+29.6
Percent Occupancy	48.7	49.6	+ 1.8

25. Going into the specifics of our utilization analysis, we find that while pediatric beds remained at 21 and obstetrical beds at 10, medical-surgical beds dropped from 94 in 1960 to 67 in 1968. This drop, which was the cause of the decrease in total beds, was due to the conversion in 1962 of a medical-surgical unit to a long-term care unit.

26. In the above table it is noted that total acute care discharges decreased; this reflects the experience in each of the specialty units. Medical discharges were 1,022 in 1960 and dropped to 755 in 1968, a 26.1% loss. The decrease in surgical discharges was even more severe since they decreased 49.8% – from 1,096 in 1960 to 550 in 1968. Pediatric discharges declined by 24.1%, from 473 to 359, and obstetrical discharges dropped to 263 from 561.

Exhibit No. 20—Continued

27. These decreases are related to a number of factors; more important are the general decline in the population, particularly of those in the 39-and-under-age groups and the loss of four general surgeons from the staff. This latter factor was the primary cause of the exceptionally high loss in surgical discharges. As for the sharp decrease in obstetrical discharges, we regard the nationwide decrease in the birth rate as having had a compounding effect on the above factors which have influenced local utilization patterns.

28. While the average daily census for all acute beds declined for the study period, the medical census managed to increase slightly – from 24.9 in 1960 to 26.7 in 1968. This is explained by the fact that the drop in medical discharges was offset by the four-day increase in the average length of stay for medical patients which went from 8.9 days in 1960 to 12.9 days in 1968. Although the average length of stay increased for the other services– 8.1 to 8.8 days for surgical patients; 5 to 6 days in pediatrics; and 3.4 to 3.7 days in obstetrics – the average daily census dropped from 24.3 to 13.3 in surgery; from 6.5 to 5.9 in pediatrics; and from 5.2 to 2.7 in obstetrics. In other words, the effect of the decrease in discharges from these services outweighed the effect of the increase in the average length of stay.

29. Turning to the occupancy rate, we find that the rate for all acute care services increased slightly (from 48.7% in 1960 to 49.6% in 1968). This is related to the rate increase in the medical-surgical services which went from 52.3% in 1960 to 59.7% in 1968. The increase for these services was due to the fact that even though their census decreased, the number of allocated beds was decreased to an even greater proportion. With 21 beds designated for pediatrics and 10 for obstetrics during the entire study period and with the decreases in the censuses for these services, their occupancy also decreased. The 1960 occupancy was 31% in pediatrics; this declined to 28.1% in 1968. The decline was even more severe in obstetrics since it dropped to 27% in 1968 from 52% in 1960.

30. At this point it is helpful to analyze the occurrences of occupancy for the individual acute care clinical services, revealing the number of days on which given census ranges occurred and, thereby, giving us a deeper insight into utilization patterns. For this purpose we used daily patient census statistics (less newborn) for the fiscal year May 1, 1968 to April 30, 1969 (Appendix, Table 5, Chart 7).

Exhibit No. 20—Continued

31. The study reveals that the occupancy rate for medical-surgical beds was over 80% on only 12 days of the year. In other words, for about 97% of the year the occupancy rate for these beds was 80% or less. Moreover, for about 30% of the year this rate was less than 60%.

32. In pediatrics we find that on only two days of the year was the occupancy rate above 60%. Lastly, in obstetrics the rate was 60% or more for only about one-quarter of the year.

33. It is apparent that all of the acute care services have been underutilized and we do not anticipate a change in this phenomenon until the current trend of a declining population is reversed and, equally important, until more physicians are added to the hospital's staff. This latter point is discussed in greater detail in a subsequent section of this report.

34. For the same twelve-month period as in the above study we have studied the average patient census in relation to its monthly fluctuations. Monthly averages for the period were calculated and expressed as percent variations from the average census, thereby indicating the months in which the various census fluctuations occurred (Appendix, Table 6).

35. From a percent variation of +1.4% in May the census rose to its high for the year in June when the variation was +8.7%. From this point the census reversed its path and declined to its low for the year in October, when the variation was -13.9%. We would usually expect a summer decline and then some increase in census in the fall months. From the October low the variation rose to +3.2% in November and then declined to +1.1% in December. This sudden drop is due to effects of the holidays. For the first three months of 1969 the variations ranged between +8.1% and +5.5%. This is typical of the increases in utilization we anticipate for these months. Lastly, in April, its variation was again below the average, at -6.1%.

36. While the monthly fluctuations are somewhat atypical of that which we would normally expect to find, they are not significant to the extent that they would alter our planning concepts.

Exhibit No. 20—Continued

37. The final measurement of hospital utilization in a service area compares local utilization rates with national experience. A summary of short-term general hospital utilization on a national basis since 1960 reveals that the national admission rate has increased steadily with only the most recent year indicating a tendency toward stabilization. Patient days per 1,000 population have also increased, with no sign of basic slowdown or reversal indicated. We are inclined, then, to consider the stabilization in admission rates as a short-term phenomenon caused by a combination of high occupancy in the medical-surgical services in our nation's hospitals; and increased selectivity of patient admissions due to this high degree of utilization which is in part related to the influence that longer-stay cases have had on use patterns. With the expansion and addition of facilities, the return of past growth in admission rate patterns is predicted (Appendix, Table 7).

38. While the national admission rate has increased from 126.1 admissions per 1,000 population in 1960 to 139.9 in 1968, the local rate has declined from 130.9 in 1960 to 84.5 in 1968 (Appendix, Table 8, Chart 8). Thus, whereas the local rate was 103.8% of the national rate in 1960 it was only 60.4% of it in 1968. This was brought about by the fact that even though the weighted hospital service area's population declined during the study period, discharges during this period fell at an even faster rate than the population.

39. Since the use patterns are not high for the acute care services, the decline in the admission rate cannot logically be based on the fact that the degree of selectivity of patients is increasing. The low admission rate, however, does suggest that the service area's population is seeking hospital care outside of the service area and also that the proportion of doctors to the total service area's population is abnormally low. This latter point is statistically illustrated in the following section of this report.

40. Lastly, we have also analyzed long-term care services of St. Mary's Hospital. As mentioned above, a medical-surgical unit was converted into a 33-bed long-term care unit in 1962. The statistical data on which our analysis of this unit is based represents fiscal years ending May 31, except for 1968 where only the eleven months ending April 30, 1969 were included.

Exhibit No. 20—Continued

41. While discharges for the long-term care unit fell off slightly from 25 in 1962 to 20 in 1968, the census rose from 23.9 to 29.7. The census increase is related to the substantial increase in the average length of stay, which went from 34.9 days in 1962 to 54.3 in 1968. As for the occupancy rate, we find that whereas it was 72.4% in 1962, it had increased to 90% in 1968. Although this latter rate would be considered relatively high in relation to acute care beds, it is not uncommon to find rates of 90% or more in long-term care units.

Medical Staff Activity

42. The previous analysis showed community and hospital trends in terms of hospital utilization. However, the hospital's caseload is also significantly affected by the availability and referral patterns of physicians using the hospital. Future community health care and hospital growth is dependent, to a great extent, on the availability of physicians and is particularly true in your case. The establishment of a recruitment program to add to your present staff and by so doing assure the replacement of your older physicians is vital. This is discussed in detail in a subsequent section of the report.

43. In order to evaluate the admitting patterns of the medical staff, discharges by physicians were documented for 1968. This study excludes radiologists, the pathologist, dental staff and those on the honorary, courtesy and consulting staffs of the hospital since these physicians do not routinely admit patients to the hospital. With these exclusions, seven physicians remain. Their age, place of office and discharges (excluding newborn) are listed below:

Analysis of Age, Office Residence and Workload of Physicians: 1968

Physician	Age	Office Address	Discharges
A	48	Cairo, Illinois	307
B	62	Cairo, Illinois	318
C	53	Cairo, Illinois	292
D	36	Mounds, Illinois	- 1/
E	57	Mounds, Illinois	313
F	54	Charleston, Missouri	351
G	42	Charleston, Missouri	316
Other	-	-	30

1/ At the time of the study, this physician was new in the area and on the staff and was working in conjunction with physician C. His discharges are therefore included in those credited to physician C.

Exhibit No. 20—Continued

SMC 1-14

44. The above analysis reveals that casework is relatively evenly distributed among those physicians who actively and routinely utilize the hospital's beds. This is evidenced by the fact that the greatest number of discharges by a physician was 351 and the least, 292; the average number of discharges per physician was 316.

45. Of the seven physicians, three have their offices in Cairo, two in Mounds, and two in Charleston, Missouri. The two physicians from Missouri use St. Mary's as their primary hospital although there is a hospital in Sikeston, Missouri of approximately the same size and equal distance from their offices.

46. As for the ages of the staff members, we find that of those in the study, two are over 55 (one is 57, the other 62). As these men approach retirement and begin restricting their own activity, younger physicians should be on hand to take over their patient load.

47. In order to see how the number of physicians in the hospital service area compares with similar data for Alexander and Pulaski Counties in Illinois; Mississippi County in Missouri; the state of Illinois; and the United States and its possessions, we formulated ratios which relate physicians to population for these areas. Information pertaining to all but the service area was derived from a report of the American Medical Association: Distribution of Physicians, Hospitals, and Hospital Beds in the U.S., 1967. Only those physicians rendering patient care in non-federal hospitals are included in the study, the results of which follow:

Physician Distribution by Population
1967

Area	One Physician for Every
Hospital Service Area	3,257 persons
Alexander and Pulaski Counties, Illinois; and Mississippi County, Missouri	2,606 persons
Illinois	809 persons
United States and its Possessions	791 persons

Exhibit No. 20—Continued

48. We thus find that while there is a physician for approximately every 800 persons in Illinois and the nation, there are about three times as many persons per physician in Alexander, Pulaski, and Mississippi Counties in relation to Illinois and the nation, and about four times as many when we compare the hospital service area to the same base figures.

49. Rural areas have traditionally had low physician-population ratios, but we consider the ratio for your hospital service area to be abnormally low. This study then gives further evidence of the need for the community to actively recruit physicians for the hospital.

Acute Care Bed Needs

50. At this point we can project the acute general hospital bed needs of St. Mary's Hospital by applying population and utilization patterns of the past to our projections for the future. These projections are based on a given set of planning assumptions which include an estimate of your future role as the primary provider of hospital care in your service area. Following are the components of our planning formula for determining bed need (Appendix, Table 9, Chart 9):

a. Population - We anticipate a reversal of the downward trend in the weighted hospital service area's population and have thus projected a population of 23,900 for 1975 and 31,700 in 1985.

b. Admission Rate - To reflect local trends we have projected the local admission rate at 80% of the projected national rate which will continue to increase.

c. Average Length of Stay - Although the local length of stay has historically been longer than that of the national average stay, it may change in the future. As a hedge against these changes we have used the projected national average stay and a stay projected at 107% of the national in order to create low and high bed projections.

d. Percent Occupancy - Allowances for daily and seasonal fluctuations are considered in the formula which states that occupancy should be at a level approximating three times the square root of the average daily census plus the average daily census.

Exhibit No. 20—Continued

51. Bed Need - The resultant bed needs for St. Mary's Hospital, based on the above planning assumptions, are shown in the Appendix, Table 9, Chart 9, and are summarized below. Of course, as the design features of the nursing units are developed, the actual number of beds may vary somewhat from these figures.

52. In addition to the acute care beds, we suggest that you also provide a long-term care unit of approximately 30 beds. Our planning concepts of this unit will be discussed in a subsequent section of the report.

53. We emphasize 1975 as the first target date for our planning objectives because of the time needed to plan, construct, and activate new facilities:

St. Mary's Hospital
Acute Care Bed Needs

	1970	1975	1980	1985
Low Projection	83	92	104	132
High Projection	88	98	110	140
Consultant's Recommendation	85	95	105	135

Departmental Utilization

54. We analyzed workloads of the major diagnostic and treatment services of the hospital for the period 1960-68 (Appendix, Table 10, Chart 10). Based on this statistical material, trends and planning criteria were established so that future workloads for these services could be projected. The following is a summary of the analysis of patients:

Exhibit No. 20—Continued

SMC 1-17

Departmental Utilization
1960 - 1968

Activity	1960	1968	Percent Change 1960-68
Laboratory Tests	37,809	41,747	+ 10.4%
Electrocardiograms	677	1,105	+ 63.2
Radiological Procedures 1/	3,906	4,264	+ 9.2
Surgical Procedures	936	270	- 71.2
Emergency Room Visits	861	2,829	+228.6
Deliveries	441	237	- 46.3

1/ Excludes therapeutic procedures.

55. In describing the above table, we note that laboratory tests, which we were unable to break down into inpatient and outpatient tests due to the method of recording, rose steadily from 37,809 in 1960 to a peak of 57,454 in 1966. Since this occurred even though discharges were on a downward trend, it appears that this increase was related to a greater number of examinations per patient and the substantial increases in total emergency room visits during this period. Although surgical procedures tend to influence laboratory workloads, they were not of a magnitude that would alter the volume of tests significantly.

56. In 1968 laboratory tests totaled 41,747, a substantial decrease from the 1966 peak. This happened even though total emergency room visits continued to make substantial increases. This decrease is even more puzzling since discharges, which continued to decline, did not however, decrease at a faster rate than they did in previous years – their loss, in fact, was less pronounced. We have found, though, that variations of this type are often related to changes in the methods used in the counting and/or recording of tests, if further evidence does not indicate otherwise.

Exhibit No. 20—Continued

SMC 1-18

57. While laboratory tests per inpatient increased on the average of about 1.2 tests per year for the study period, we have modified this rate to reflect the recent downward path of the laboratory workload. With this in mind we have projected tests on the basis of an average annual increase of .9 tests per inpatient. Thus, by 1975 we anticipate 28 tests per inpatient or approximately a total of 80,400 laboratory tests.

58. In 1960 there were 677 electrocardiograms and by 1968 these had risen to 1,105 for about a 63% increase. We suspect that some of this growth was a result of the medical care program in the long-term care unit.

59. Diagnostic radiological procedures remained relatively stable between 1960 and 1962 since they increased only to 3,948 from 3,906; in 1964 they jumped to 4,364, and stabilized through 1966 when they were 4,329. However, in 1968 procedures declined somewhat to 4,264.

60. A more detailed look at diagnostic radiological procedures reveals that whereas inpatient procedures rose from 2,603 in 1960 to 3,035 in 1964 and then decreased to 2,817 in 1968, outpatient procedures remained relatively stable from 1960 to 1964 (1,303 procedures in 1960 and 1,329 in 1964) and then increased to 1,447 in 1968. This indicates that the decline in total diagnostic procedures between 1964 and 1968 was related to the decline in the inpatient procedures.

61. In projecting diagnostic radiological procedures we have adjusted the average annual increase of about 1.2 procedures per inpatient experienced between 1960 and 1968, to reflect the recent decline in inpatient procedures. We thus anticipate 2.8 diagnostic procedures per inpatient by 1975 or approximately 8,050 procedures.

62. Although the radiology department has deep therapy equipment, it is not effectively utilized. No therapeutic procedures are recorded for 1960. In 1962 there were 37. These declined to 7 by 1968. The nominal workload for this equipment suggests that there are patients utilizing hospitals outside of the service area for radiologic therapy.

Exhibit No. 20—Continued

SMC 1-19

63. Surgical procedures have decreased steadily from 936 in 1960 to 270 in 1968. This phenomenon is directly related to the loss of four general surgeons from the staff between 1960 and 1968. Because of the steady decline in surgical procedures during the study period and since the future number of surgical procedures is related to the success of the hospital in augmenting the present number of physicians having surgical privileges, there is little substance from which accurate projections can be made. However, by basing our projections on the assumption that surgical procedures per inpatient will not be more than .30, which is the high for the 1960-68 study period, we feel there is little chance of the workload to go much higher than 850 procedures. We note, moreover, that the hospital currently has two general-use operating rooms which are satisfactory for future use. Using our planning standards of a maximum of 1,000 surgical procedures per room we find that there are more than ample facilities to handle any future increase in the surgical workload.

64. Total emergency room visits, which include both emergency and non-emergency (convenience) visits, were 861 in 1960. These rose to 2,829 in 1968 for a 229% increase. This is not unusual since emergency department activity has been accelerating sharply in our nation's hospitals.

65. Further analysis of total emergency visits reveals that whereas true emergency visits rose from 619 in 1960 to 1,851 in 1968 for an overall increase of 199%, convenience visits have increased by about 304% – from 242 in 1960 to 978 in 1968. Again this phenomenon is not atypical since the emphasis of emergency service, on the national scene, is now on the convenience and non-emergency visit rather than the true emergency. This has come about because of:

a. Sociological factors related to increased mobility of the population and the resultant lack of continuing ties with a "family" physician.

b. The declining availability of the "family" physician, twenty-four hours a day, seven days a week.

c. The convenience to physicians when their offices are closed, when they are at the hospital, or when consultations may be indicated.

Exhibit No. 20—Continued

d. The trend toward considering the hospital as the focal point of health care in the community and the availability there of complex diagnostic tools.

66. In your case we project the future workload of the emergency room on the basis of a rate measuring total emergency room visits per 1,000 population. Since the local rate has in the past been about 66% lower than the national rate, we have adjusted our projected 1975 national rate to reflect local conditions. Thus by 1975 we project 178 visits per 1,000 population or a total of approximately 4,300 emergency room visits.

67. Lastly, deliveries decreased from 441 in 1960 to 237 in 1968. This decrease is related to the drop in the birth rate which has been experienced nationally since 1961. There is evidence on the national level, though, that the decrease is stabilizing. This indicates that some increase in the number of births can be expected in the future due to an increase in the childbearing population. Since, as was mentioned previously, an increase in the population is anticipated on the local level as the socio-economic characteristics of the area are revitalized, the hospital should expect a gradual, long-range increase in births. Since we feel that a delivery room can handle up to 1,000 deliveries per year, the hospital is well equipped, with its two delivery rooms, to handle increases which may occur inasmuch as deliveries in 1968 totaled only 237.

68. In conclusion, we note that as with any projection, our predictions are not to be considered infallible. They should serve rather as planning tools which, since based on current data, will require adjustment if our present planning bases are changed in the future.

Exhibit No. 20—Continued

SMC 2-1

SITE, PARKING AND PLANT EVALUATION

Site and Parking

1. The hospital is located about three-fourths of a mile west of the central business district of the city of Cairo. The relatively flat plot on which the hospital complex is located approximates three acres. Bordering this site to the northeast is Walnut Street; to the southwest (the side which the front of the hospital faces), Cedar Street; and to the northwest, Center Street; and to the southeast, Cross Street.

2. Besides the above plot, the hospital has a corner plot on the northwest corner of the junction of Cedar Street and Cross Street. On this property of about .41 of an acre is located the nurses home. This property is also relatively level. Also, on the northwest side of Center Street the hospital owns a single residential-sized plot.

3. As for off-street parking, the hospital has a total of 12 spaces on its own property. These spaces are reserved for doctors and are located adjacent to the emergency entrance. Furthermore, through an agreement with the Illinois Central Railroad, the hospital is able to utilize a piece of the railroad's property for parking. This property is diagonally south of the main entrance of the hospital which runs parallel to Cedar Street. This strip of property can accommodate only about 15 automobiles. It was reported that the future availability of this property is not assured due to plans for it which the railroad hopes to implement in the near future. Therefore, in relation to our desirable goal of one and one-fourth off-street spaces per bed, the present number of spaces is inadequate as it also is in relation to our minimum standard of one space per bed.

Physical Plant

4. The following comments refer to the hospital's structure:

5. 1923 Structure - This building has a basement and three floors, and has the following construction characteristics:

Exhibit No. 20—Continued

SMC 2-2

Foundation and Excavations:	Concrete footings and piers.
Basement:	
Frame:	Reinforced concrete and wood columns and girders, load-bearing wall.
Floor:	Concrete on ground, some asphalt tile cover.
Ceilings:	Flat, finished plaster in finished areas.
Exterior Walls:	20" concrete and brick walls, plaster and finished wall interior.
Interior Partitions:	Wood and masonry partitions.
Superstructure:	
Frame:	Reinforced concrete frame for halls, wood beams and posts, load-bearing walls.
Floors:	Reinforced concrete in corridors; hard and soft wood in other sections; ordinary joists, soft wood in attic.
Ceilings:	Flat, plastered.
Roof Structure:	Gable and valley roof, wood rafters and sheathing.
Roof Cover:	Composition shingles.
Interior Construction:	Wood and masonry partition walls.
Extension Walls:	8", 12" and 16" brick walls, double-hung wood sash, interior plastered and finished, brick porte cochere.

Exhibit No. 20—Continued

6. This building has been rated as being of nonfire-resistive construction by the State of Illinois Department of Public Health. Thus, all the beds in this structure are nonconforming. We concur with the department's rating and suggest that this building be removed.

7. Maintenance Building - To the northwest of the 1923 structure is the two-story maintenance building. The following are some of its construction features:

Foundation and Excavation:	Concrete footings.
Superstructure:	
Frame:	Open steel frame.
Floors:	Concrete on ground, reinforced concrete top floor.
Ceilings:	Plastered top floor.
Roof Structure:	Flat roof, wood rafters and sheathing.
Roof Covering:	Composition.
Interior Construction:	Wood and concrete block.
Exterior Walls	12" common brick and some concrete; wood windows.

8. 1953 Structure - The State of Illinois Department of Public Health rates this structure, which has a basement and three floors, as being fire-resistive. We agree with this finding and add that the building is relatively modern and structurally sound.

9. Because of poor soil conditions the building required the flotation design of the entire basement floors and walls as an integral unit. The structural framing system of the upper floors is of reinforced concrete columns, beams, and floors, with nonload-bearing masonry walls. It was also reported that this building was not designed for additional floors except for the exterior of the southwest portion of the top floor. This was constructed incompletely at the time of its construction because of budgetary limitations.

Exhibit No. 20—Continued

SMC 2-4

10. Nurses Home - This building, which has two floors, is of reinforced concrete construction with a brick veneer. With this type of construction the building is considered to be fire-resistive.

11. An inventory of the functions and departments located within the structures described above follows:

1923 Structure

Floor	Function
Basement	Housekeeping, subsidiary sections of central stores and storage, central supply department, central personnel facilities, linen, and mechanical.
First	21 beds - pediatrics. 28 beds - medicine and surgery.
Second	33 beds - geriatrics.
Third	Pharmacy, subsidiary sections of administration and dietetics (sisters' dining facilities).

Maintenance Building

Ground	Mechanical
First	Maintenance shop.

Nurses Home

First	Tri-County Health Department, Community Service Center and unassigned areas.
Second	Sisters' living quarters.

Exhibit No. 20—Continued

SMC 2-5

1953 Structure

Floor	Function
Basement	Boiler room, main sections of laundry and linen, central stores and storage; subsidiary portions of pathology, dietetics, radiology, central personnel facilities, and mechanical.
First	Outpatient care facility, main portions of administration, pathology, radiology and dietetics.
Second	31 beds - medicine and surgery; operating and recovery suite and main portion of central supply department.
Third	8 beds - surgery. 10 beds - obstetrics; newborn nurseries. Labor and delivery suite.
Penthouse	Mechanical.

Departmental Analysis

12. Introduction - Administrative and patient care areas, diagnostic and treatment facilities, and service departments were analyzed in terms of space adequacy, location, logical work flow, operating efficiency, and interdepartmental relationships. Departmental areas have been compared with recognized size standards. These were further studied and modified to meet the specific needs of your hospital. The existing and recommended departmental areas are detailed in the Appendix, Table 11, Chart 11. These are, of course, gross calculations of approximate net square footage, eliminating corridors, circulation space, etc., and are subject to intensive study in detailed architectural planning. They do, however, offer a valid basis for determining overall departmental space adequacies. Specific findings concerning each department and function will be found in the following paragraphs.

Exhibit No. 20—Continued

SMC 2-6

Administration

13. For purposes of this report, we have included in this category the following: public areas, administrative and fiscal offices, admission area, medical records, and medical staff facilities. The total combined space of these facilties approximates 103% of current and future space needs. But while there are space overages in certain areas in this category, there are space shortages in others. Along with a critique of space we also note other design features:

14. Public Areas - This category includes the public waiting area, the public rest rooms, and the chapel. All these facilities are convenient to the main entrance and to each other. The elevator leading to the nursing unit on the second floor of the 1953 structure is in the immediate vicinity of the public waiting area and the elevator leading to the nursing units is easily accessible from this latter area. The space allotted to these individual areas is also adequate.

15. Administrative Offices - Included in this category is the administrator's office, the personnel office, and the social service office (vacant at the time of the consultant's visit but which is to be utilized for social service or a related function in the near future).

16. Although we find the space and location of the administrator's office and the social service office satisfactory, we note that the location of the personnel office is unsatisfactory. Because of its location on the third floor of the 1923 structure it is not easily accessible to job applicants. It should be situated in an area near the main entrance of the hospital. The total space currently allocated to the office, though, appears adequate in relation to our standards except that no area is provided for the completion of applications within the office. Job applicants currently use a lounge adjacent to the office. This lounge is also available for use by maternity patients.

17. Nursing Office - The nursing department utilizes the services of, and is related to, most hospital departments. It also accounts for a substantial part of the hospital budget. It needs quick, frequent, and direct contact with top administration for policy and decision making. With the nursing office close to the administrator's office, nursing becomes a part of general administration and any tendency to become a separate entity is obviated. We therefore endorse the present location of the nursing office but note that its current space assignment is inadequate for present and future needs.

Exhibit No. 20—Continued

SMC 2-7

18. Fiscal Services - The location of the main business office is satisfactory but, taken as a whole, the facilities in this category have inadequate space. The shortage of space has necessitated designating the room behind the service elevator, which was originally provided for storage, as a posting room. This room is unsatisfactory since it is relatively distant from the main business office and poorly ventilated.

19. The credit office, too, is decentralized from the main business office. This is unfortunate since the two should be contiguous to each other because the credit office utilizes the records of the business office to a great extent. With the current situation much time is wasted in traveling between the credit and business offices.

20. Admitting - In its first floor location, the admitting office is easily accessible from the main entrance. We note, however, that steps have to be traversed to gain access to the office from this entrance or to leave the hospital via this means. Since this situation creates difficulties, particularly for the non-ambulant and those having trouble walking, the ramp at the emergency entrance is now used by these types of patients when admitted or discharged. But this ramp itself is somewhat of an obstacle since it is relatively steep. Also, once on the platform at the top of the ramp, maneuvering those in wheelchairs and particularly those on stretchers, is difficult because of the limited amount of space in this area. However, one advantage of the admitting office's present location is its proximity to the laboratories, making the collection of blood specimens from the admitted patient easier.

21. As for space, we feel that the office, which is poorly ventilated, is too small and lacks its own waiting area.

22. Medical Records and Medical Staff Facilities - These facilities are currently located on the third floor of the 1923 structure. A record storage room which is shared with the business office is also located in the basement of the 1953 structure. Our primary planning factor in relation to medical records is locating it close to medical staff facilities, particularly the medical staff lounge. While this criterion has been fulfilled, we note that the poor location of the medical staff facilities has adversely affected the effective operation of medical records. Because of their out-of-the-way location, the facilities are only occasionally used. Thus the physicians are not routinely in the area of medical records. We plan medical staff lounges adjacent to medical staff entrances, thus making them convenient for the physician.

Exhibit No. 20—Continued

23. It was reported that medical record personnel were experiencing difficulty in getting physicians to complete their records. This, no doubt, is to a great extent due to the locational aspects of the department as described above.

24. We note that while the medical staff facilities have more than adequate space for current future needs, medical records has insufficient space, particularly for work areas. Also lacking is a physician dictating area in a section of the department or adjacent to it.

Pathology

25. This department is housed on the first floor of the 1953 structure and is conveniently located in relation to the outpatient care facility. It is also easily accessible to the nursing units and operating and recovery suite since the service elevator is close to the department.

26. As a preface to our space analysis of the department, we indicate that there are procedures used in the planning of this department which can be applied to arrive at a gross identification of its space needs. In concept, the volume of activity is translated to personnel and equipment needs which are in turn converted to required space. Caution and close periodic evaluation must be applied in planning future pathology facilities since we are currently in an era of changing approaches to laboratory work, with a significantly greater degree of automation. Thus, planning formulas are constantly being adjusted. Automation has led to a greater degree of productivity per technician, thus reducing the number needed for a given volume of work but leading to a greater space need for equipment. In addition, as laboratory work becomes more comprehensive there is the influence of more tests which are constantly being introduced. Hence, our measurements, although based on anticipation of change, may be conservative.

27. Our departmental space analysis indicates that pathology as a whole approximates 64% of the space currently needed and of that which we have planned for the future. Looking more closely at the current space situation, we note that all the areas of the department are allotted insufficient space.

Exhibit No. 20—Continued

28. Some of the more specific inadequacies of the department are as follows:

a. There is no space allocated for the clerical functions of the department. Such an area could be so situated that it could also function as a reception/control area. Furthermore, the waiting area, which is a partitioned section of a corridor, has inadequate space.

b. No office is provided for the pathologist or chief technologist.

c. Storage space for supplies, equipment and records is generally inadequate.

d. Laboratory space is inadequate for current needs and for the future needs of the department.

e. The morgue and autopsy area lacks a shower and dressing facilities. Furthermore, the area lacks a mortuary refrigerator. Bodies are now kept on a stretcher in the autopsy room, which is not air-conditioned, until the autopsy.

f. There are no lounge and locker spaces for personnel. We plan these facilities within the department, or if practical, in an area which allows sharing of facilities with another diagnostic or treatment department.

g. Lastly, a small room at the end of the corridor, off which the department is located, is currently used for electrocardiograms, basal metabolism rates and the Master two-step procedure. This room also lacks sufficient space, and further comment is made in a subsequent section of this report.

Radiology

29. In terms of specific space needs, we project the number of diagnostic units on the basis of 6,000 examinations per unit per year as a normal operating level. While this presumes a balance of types of work requiring varying amounts of time, we do not feel that your balance

Exhibit No. 20—Continued

is significantly different from the average. Applying these criteria to the projected workload results in a need for two diagnostic units by 1975. There may be pressures on hospitals in general to extend the hours and days during which some diagnostic and treatment services are offered; however, even with these modifications of policy, we foresee only a minimal adjustment in the projection of need.

30. The department currently has two diagnostic rooms and a therapy room. These rooms, plus the remaining space of the department, approximate 53% of what is needed at this time and in the future. This, according to our standards, consists of a department with two diagnostic rooms, both equipped with image intensification devices for fluoroscopy, but with no therapeutic facilities. With two rooms set up for fluoroscopy, the department is made more efficient since the radiologist can work back and forth between the rooms. While he is working in one, the patient in the adjacent room can be prepared; thus, less time is needed per patient for procedures. Furthermore, an emergency case needing radiography can always be accommodated in the room where the radiologist is not immediately engaged.

31. The shortage of space is, in part, due to the fact that neither diagnostic room meets our minimum space standards for the two rooms we recommend. Rooms with fluoroscopy equipment should have minimum dimensions of 16' x 18' excluding the control area. These dimensions allow for the easy maneuvering of stretchers into, out of, and within the rooms.

32. The following are some of the more specific inadequacies of the department:

a. Besides the therapy room being too small, it was reported that when it is in use, x-rays leak through the floor to central stores. Before therapy procedures can start, personnel in central stores are therefore told to leave this area so that they will not be exposed to the stray rays.

b. The doors to both diagnostic rooms are not lead lined.

c. The control area in Room #2 is not adequately protected.

Exhibit No. 20—Continued

d. The waiting area is too small. Furthermore, good public relations requires some differentiated space for inpatients in wheelchairs and on stretchers, for gowned outpatients and for the reception and control of other patients.

e. Record file storage space is inadequate within the department. Currently, 1968's files are stored in the therapy room. Our standards call for a minimum of two years of active files to be stored within the department to help lessen the time spent traveling between the department and the file storage area.

f. There is insufficient storage space for supplies and equipment, particularly for the portable x-ray machine, wheelchairs, and stretchers. This equipment is stored in the diagnostic rooms or, when these areas are in use, in the corridor. Furthermore, linen must be stored in Room #2.

g. The water closet for Room #1 is poorly designed since access to and egress from it can be had only by going through the diagnostic rooms. This hinders the optimal operation of the room.

h. There is no lounge or locker area in the department. Such an area is not merely a convenience; with it there is less reason for personnel to leave the department during the day. It is sometimes possible to plan such a facility in conjunction with other diagnostic and treatment departments, thereby cutting back on the need to duplicate these areas.

i. The department lacks separate areas for clerical functions, file viewing, and radiologist's office space. Currently, only one room is utilized for all these functions and activities.

33. While the present location of the department affords proximity to elevators and the outpatient care facility, we suggest the relocation of the department to an area of relative convenience which would also provide the space needed for the department's expansion. We also suggest that the therapeutic program and facility of the department be eliminated as it relocates. In 1968 there were seven

Exhibit No. 20—Continued

therapeutic procedures. Such a workload simply does not justify a facility at the hospital for this purpose. Patients needing such services can utilize hospitals in surrounding areas which are better equipped and staffed for such a program.

Physical Medicine and Special Services

34. Physical Medicine - Although the hospital currently does not offer physical medicine, the potential need for such facilities is significant particularly in light of your commitment to a program of aged-care. We have, therefore, provided space for this service in our proposals.

35. Our planning concepts for physical medicine, which should be provided with strong physician direction, include space provisions for the following:

a. A waiting area with a toilet. If possible, the waiting area should be used by other services to avoid duplication and to effect maximum utilization of this facility.

b. A general office for use by the department's staff and physicians.

c. A hydrotherapy room incorporating materials providing water protection and humidity control.

d. A large treatment room providing treatment cubicles for different modalities.

e. A functional exercise room within the general treatment area. This arrangement will allow a therapist to work simultaneously with several patients.

f. A patient training toilet.

g. Utility and storage space.

h. Locker and toilet facilities which can be shared with adjoining services.

Exhibit No. 20—Continued

36. Special Services - As with physicial medicine, special services (which in the hospital's case relates to electrocardiography, inhalation therapy and pulmonary function) have a potential for growth. Currently, a room at the southeast end of the corridor where the laboratory is located is used for special services. The size of this room is already inadequate and prohibits further growth. Our proposals for the hospital include enough space and a satisfactory location for the efficient and effective operation of these services.

Outpatient Care Facilities

37. The outpatient care facility is close to radiology, pathology and the elevators; thus, its present location is satisfactory. Furthermore, although this facility lacks sufficient space to meet current and future needs, this location allows for expansion with a minimum of effort. We therefore suggest that the facility remain in its present location and expand by taking over space now used by administration.

38. Some of the specific inadequacies of this facility are as follows:

a. An adequate waiting area is lacking. This should be adjacent to a control area where the clerical functions of the facility are based.

b. Space is lacking in relation to treatment and examining areas. With the growing acceptance of the concept of outpatient care as a community service, there will predictably be an increase in non-emergency outpatient visits. The increase in this type of activity calls for the expansion of these examining and treatment facilities.

c. Adequate utility areas and storage areas for supplies, equipment and linen are lacking.

d. The facility lacks piped oxygen and suction.

e. Entrance to the emergency room lobby with a stretcher via the single door adjacent to the ramp is difficult because of the limited amount of space provided.

Exhibit No. 20—Continued

f. It was reported that the air-conditioning system for this facility does not effectively keep the temperature at desirable levels.

Operating and Recovery Suite

39. The operating and recovery suite is located on the second floor of the 1953 structure. Although this location places it on a different floor from the diagnostic and treatment services, it is near the service elevator which makes travel to and from these areas relatively convenient.

40. Currently, the suite has two general-use rooms and a fracture room. There is no cystoscopy room (cystoscopic work is generally referred to hospitals in Paducah or Cape Girardeau), and the two rooms which were originally designed as minor operating rooms are used for other functions - one as the recovery area and the other as an equipment storage room. Our projections indicate that these facilities will be adequate to accommodate the workload to at least 1975. While the suite is modern and the operating rooms are adequate in number, there are a few deficiencies primarily related to the design features of the suite. We note the following examples:

a. The operating rooms have single-thickness windows which can be opened, thus adversely affecting the degree of antisepsis strived for in these rooms. Furthermore, it is often difficult to maintain proper temperature and humidity levels with single-thickness windows. In fact, it was reported that the suite was experiencing this latter difficulty.

b. The operating lights in each of the operating rooms are stationary and are recessed into the ceiling. Thus, to focus the lights on the surgical field, the operating table must be moved. Adjustable ceiling-hung lights would be more effective and easier to work with.

c. The suite lacks a voice communication system.

Exhibit No. 20—Continued

d. It was reported that the results of conductivity tests, which are done monthly, are often not within the currently accepted range of 25,000 ohms to 1 megohm. We suggest that the source of the problem be uncovered and remedied. Often housekeeping techniques are responsible for unacceptable conductivity levels.

e. We note that the louvered radiator grills need cleaning. All grill and air-handling vents should be routinely cleaned since they are breeding places for contaminants.

f. The substerile room which connects the operating rooms in use is not separated from these rooms by doors. Thus, airborne contaminants in one room can easily contaminate the substerile room and the adjoining operating room.

g. The location of the administrative area for surgical scheduling, patient and personnel control, and other related functions is inadequate. This area should be located at the entrance to the suite where it would be more effective.

h. The nurses lounge and locker areas are located outside the suite off a public corridor. Desirably, such an area should be designed to allow a nurse in proper surgical attire to enter directly into the suite.

i. Currently, anesthesia gas cylinders are stored in the equipment storage room (formerly a minor operating room). Furthermore, cyclopropane cylinders are stored in the suite's office area; they should be stored in a properly vented room provided solely for this use.

j. The suite lacks a janitor closet.

41. In addition to its above deficiencies there are space inadequacies within the suite. For instance, none of the operating rooms meet our minimum space standard of 18' x 20' (360 square feet) or the desirable dimensions of 20' x 20' (400 square feet). In your case, the two general-use operating rooms are about 14.5' x 17.5' (254 square feet). The recovery room (a former minor surgery room)

Exhibit No. 20—Continued

is also inadequate in size. Using our standard of 1.5 recovery beds per operating room, there should be three recovery room beds. Furthermore, 80 square feet per recovery room bed and 120 square feet for nursing service areas are called for by our standards. While we do suggest that changes be made to remedy the inadequacies we have listed, we do not think that the space deficiencies are of such a serious nature as to warrant a major remodeling of the suite. This approach seems even more logical when we consider the fact that these space inadequacies do not appear to adversely affect the functional operation of the suite to any significant degree. The suite is relatively modern, conveniently located, and has what is basically needed in respect to facilities.

Labor and Delivery Suite

42. The labor and delivery suite is located on the third floor of the 1953 structure and is easily accessible to the service elevator, the nurseries, and the obstetrical unit. It has two delivery rooms, one of which is used on rare occasions as a labor room; and a labor room having two beds. We generally plan delivery rooms on the basis of 1,000 deliveries per room per year. Since deliveries have gone from 441 in 1960 to 237 in 1968, the two delivery rooms are more than adequate for current needs. Since we do not foresee the number of deliveries outstripping the ability of the two delivery rooms to accommodate them, it appears that they will be adequate for future needs.

43. Our standards call for one labor bed for every ten obstetrical beds. There are currently ten such beds, which seems sufficient at least until after 1975. Thus, the number of labor beds is adequate for current and future needs. As we stated above, these two labor beds are situated in a single room, whereas we prefer private labor rooms. Patients not having difficulties in labor are often made anxious by being in a semi-private labor room with a patient having such difficulty. Also, as the demand increases for allowing husbands to remain with their wives in the labor room, so too will the need for private labor rooms. The occasions, though, when there is more than one patient in labor at a time are not great enough to warrant the change of its present arrangement. Furthermore, in the case of the hospital, there has been little interest exhibited on the part of fathers wishing to be with their wives in the labor room.

Exhibit No. 20—Continued

44. The following problems were found to exist in the suite, many of them similar to those found in the operating and recovery suite:

a. Those inadequacies common to the operating and recovery suite are:the lack of a voice communication system; the fact that the delivery rooms have single-thickness windows which can be opened; louvered radiator grills in need of cleaning; and an ineffective air-conditioning system.

b. The delivery rooms are without ceiling-hung operating room type lights. A portable light is used for deliveries. This is unsatisfactory since the floor space around the obstetrical table should be kept as clear as possible to allow easy accessibility to the patient.

c. Gloves are powdered in the cleanup room. This activity should be centralized in an area of the central supply department where any airborne powder particles would not contaminate other rooms, equipment and supplies in the vicinity of the powdering operation.

d. We note that the delivery rooms approximate 14. 5' x 18' (261 square feet) as opposed to our standards of 18' x 20' (360 square feet). However, since it was reported that these space inadequacies do not lower the effectiveness of these rooms, we do not advocate their expansion.

e. Although the suite has a janitor closet, it is used as a storage area and is thus not functioning as it was designed to.

Nursing Units and Newborn Nurseries

45. The nursing units are divided between the 1923 hospital complex and its 1953 addition. In the 1923 structure are a 28-bed medical-surgical unit and a 21-bed pediatric unit on its first floor, and a 33-bed geriatric unit on its second floor. As previously mentioned, the State of Illinois Department of Public Health has rated this complex, and consequently its beds, as nonconforming primarily because of the building's nonfire-resistive construction.

Exhibit No. 20—Continued

SMC 2-18

46. The 1953 structure contains a 31-bed medical-surgical unit on its second floor and a nursing unit on its third floor with 10 obstetrical beds and 8 beds for clean gynecological patients.

47. Since our bed projections do not reflect the need for an additional number of beds over and above the present bed complement, our planning objectives will be concentrated on replacing the nonconforming beds in the 1923 structure and providing sufficient space for the professional and operational service patients. Furthermore, there are certain inadequacies of the nursing unit in the 1953 structure which should be corrected in the hospital's modernization process.

48. Although we have based the writing-off of the units in the 1923 structure on the single premise of their being located in a nonfire-resistive building, there are other deficiencies in these units which make them substandard. We feel that by mentioning some of these specific deficiencies, you will have a better basis on which to plan your future nursing units. Hence, taking the nursing units by specialty division and building, we make the following comments.

1923 Structure

First Floor

49. Medicine-Surgery - All the patient rooms are adequate in size in relation to U. S. Public Health Service Standards (U. S. P. H. S.) which require a minimum of 80 square feet per bed in multi-bed rooms and 100 square feet per bed in single-bed rooms. (These measurements exclude vestibules and water closets.) However, according to our planning standards for patient rooms, which are more stringent than those of the U. S. P. H. S., your sizes are not satisfactory.

50. We consider the following space criteria: ease of movement of patients on wheeled equipment (including beds) in and out of a room without moving other beds or furniture; free access to both sides of the bed; and allowance for extra patient monitoring and systemic support equipment to be moved into the room as needed. Therefore, we set minimum room dimensions at 12. 5' in width and 21' in depth, including the toilet and lavatory we provide for every room, or 12. 5' by 16' excluding the toilet and vestibule area.

Exhibit No. 20—Continued

SMC 2-19

51. We design all rooms with the above dimensions so that they may accommodate two beds at the most. Thus, in times of emergencies or abnormally high census, the private rooms can be easily converted into two-bed rooms.

52. Following are some of the other inadequacies of the unit:

a. The majority of the patient rooms are without toilets or lavatories. While the convenience aspect of lavatories is obvious, their desirability is primarily related to proper antisepsis technique. As for toilets, the U.S.P.H.S. requires that they shall be directly accessible from each patient room without going through a general corridor. Furthermore, we recommend that toilets be equipped with bedpan flushers, thus increasing operating efficiency. We also note the inadequate number of bathtubs and showers on the unit. Our standards call for a minimum of one bathtub or shower for every eight beds. If a bathtub and shower are provided in this ratio, they should be in separate areas to allow for simultaneous use.

b. Although the width of the unit's corridor is satisfactory, it is partially obstructed by a refrigerated water fountain. This is in violation of safety codes of regulatory agencies (e.g., U.S.P.H.S.).

c. Patient rooms are inadequately lighted and have exposed steam pipe radiators. Radiators of this type are hard to keep clean, are breeding places for contaminants, and subject patients to the danger of being burned.

d. Nursing service facilities are generally inadequate since the unit lacks: a conference room; a nurses lounge and locker area; sufficient storage area for supplies, equipment and linen; and a clean utility room separate from a soiled utility room.

e. The unit lacks a janitor closet. Currently, housekeeping equipment and supplies must be stored in a water closet in the unit.

Exhibit No. 20—Continued

f. All the doors to the patient rooms have permanently opened louvers; they should be of the solid wood type. Furthermore, the door widths of the patient rooms are below the U. S. P. H. S. standard of 3'8" and our standard of 4'.

g. The U. S. P. H. S. has set four patients as a maximum for one patient room. The unit currently has a seven-bed room.

h. Although the unit is equipped with an audiovisual nurse-call system, it is not of the type designed for voice communication – such capability would increase the efficiency of the nursing staff. We also note that none of the toilet rooms of both areas in the unit are equipped with nurse-call systems.

i. The unit lacks an examining/treatment room.

53. Pediatrics - Besides having inadequacies which are comparable to the above medical-surgical unit, pediatrics has unique major deficiencies. The following is a list of our findings on the unit:

a. Foremost is the fact that the unit fails to meet current standards governing dead-end corridors. The National Fire Protection Association's (N. F. P. A.) Life Safety Code states that "every exit shall be so arranged that no corridor has a pocket or dead-end exceeding 30 feet in which occupants might be trapped." Exits should be situated so that they are accessible directly from a corridor and not within a patient room or nursing service area.

b. The corridor doorway leading to the unit is too narrow to permit the easy movement of beds, wheelchairs and other such equipment in or out of the unit.

c. The location of the nurses station is unsatisfactory since it does not provide for the optimal control and observation of the unit. This is particularly relevant in relation to pediatrics, and for this reason an attempt was made to create a substation in the main corridor of

Exhibit No. 20—Continued

the unit. This area, however, is useful for charting purposes only.

d. As with the adult units, the U.S.P.H.S. states that the maximum room capacity should be for four patients. Currently, the unit has an eight-bed room and a seven-bed room.

e. The unit lacks a janitor closet, a playroom, a clean utility room, and a soiled utility room, an adequate examining/treatment area (whereas it is now located within the eight-bed room, a separate room should be provided for this purpose), a nurse-call system with voice communication capabilities, sufficient bath and shower facilities and adequate lighting.

f. The unit has exposed steam pipe radiators. As previously mentioned, these are hard to keep clean, are breeding places for contaminants, and subject patients to the danger of being burned. The latter situation is particularly relevant in this unit.

g. There is only one water closet to service those rooms without their own. One toilet room should be provided for each sex with a minimum ratio of one for each eight beds excluding bassinets.

h. None of the patient rooms have piped oxygen or suction.

Second Floor

54. Geriatrics - We compliment the hospital on its geriatric program; it is the only local organization which has recognized the shortage of these types of beds in the area and has instituted a program to ameliorate the problem.

55. While the unit provides certain of the required features (a recreation area, a dining area, handrails in the corridors) it has many substantial inadequacies. We have listed these as follows:

Exhibit No. 20—Continued

a. Some rooms are without lavatories.

b. The majority of the rooms do not have adjacent water closets accessible directly from the room.

c. The lighting in the unit is poor.

d. The unit has exposed steam pipe radiators.

e. None of the rooms have piped oxygen or suction.

f. Some of the patient rooms are without a nurse-call system. Furthermore, none of the toilet rooms are equipped with such a system.

g. As in pediatrics, an exit is not provided at the north section of the unit directly off the corridor to conform to the N. F. P. A. 's code - "every exit shall be so arranged that no corridor has a pocket or dead-end exceeding 30 feet . . ." These exits should be situated so that they are accessible directly from a corridor and not within a patient room or nursing service area. Currently, passage through the dining room is required to reach the fire escape.

h. The unit lacks an adequate number of bathtubs and/or showers.

i. Nursing service areas are inadequate; an examination/treatment room is lacking; a clean utility area, separate from a soiled utility area is lacking; and the unit lacks adequate storage areas for supplies, equipment and linen, and for a conference room.

j. The doors of the patient rooms are louvered and not of the solid wood type.

56. As we have noted, the 1923 structure is nonfire-resistive; there is much wood in its frame, floors, and roof. Furthermore, the building is far from modern with its high ceilings, poor lighting, and insufficient plumbing equipment. Lastly, the nursing units within the structure have numerous major deficiencies. With this, we strongly

recommend that this building be removed as the beds in it are replaced as depicted in our proposals and recommendations.

1953 Structure

Second Floor

57. Medicine and Surgery - Although this unit is relatively modern and is in a fire-resistive structure, it nonetheless has shortcomings. We make the following comments:

a. Although all the patient rooms in the unit have lavatories, the majority are without water closets.

b. All the patient rooms have piped oxygen but none have piped suction.

c. All the patient rooms have audiovisual nurse-calls but the system is not capable of voice communication. Furthermore, none of the central patient toilets or bath areas have nurse-call equipment.

d. All the doors of the patient rooms have louvered grills whereas they should be of the solid wood type.

e. The unit lacks adequate isolation facilities for those prone to infections as well as for those suffering from infections. The U.S.P.H.S. states that they should be provided on the basis of one for each 30 beds or major fraction thereof, if the hospital does not have a separate contagious disease unit. Each isolation room should have:

(1) Only one patient per room.

(2) A lavatory within the patient room or toilet room.

(3) A view-window for nursing observation.

(4) A separate toilet room with bath or shower.

Exhibit No. 20—Continued

(5) An anteroom with adequate facilities to maintain aseptic conditions, including lavatory or sink (one anteroom may serve several isolation rooms).

f. The unit lacks its own patient lounge. Although the lounge in the connecting-way between the 1953 structure and the 1923 structure is available, a ramp must be traversed in order to gain access to it.

g. The unit also lacks: a lounge and locker area for nurses; an examination/treatment room; an adequate ratio of bathtubs and/or showers per bed; adequate separation between clean and soiled utility areas.

Third Floor

58. Obstetrics/Gynecology - This nursing unit, which has ten obstetrical beds and eight clean gynecological beds, is similar in its design features to the medical-surgical unit on the second floor. The more significant inadequacies of the unit are as follows:

a. The medication area,which is too small, is not connected to the nurses station.

b. Although a lounge area is provided, it is deficient in space and rather sparsely appointed.

c. The ratio of bathtubs and/or showers to beds is too low.

d. Although the patient rooms have piped oxygen, they do not have piped suction.

e. All the patient rooms have audiovisual nurse-calls but the system is not capable of voice communication. Furthermore, none of the central patient toilet or bath areas have nurse-call equipment.

f. The clean and soiled utility areas are inadequately separated.

g. The majority of the rooms lack adjacent toilets.

Exhibit No. 20—Continued

59. Except for the above inadequacies in the nursing units of the 1953 structure, we feel they are otherwise satisfactory. We thus suggest that these units be integrated with our proposals for the modernization of the hospital.

60. Newborn Nurseries - The newborn nurseries are located on the third floor of the 1953 structure and thus are convenient to the labor and delivery suite, the obstetrical unit and an elevator. Furthermore, according to our space study the nurseries have more than ample space to meet current and future needs.

61. Our planning standards call for a minimum of one term-nursery bassinet for each obstetrical bed and an additional ten percent for suspect cases. A minimum of 24 to 30 square feet should be allocated for each term-nursery bassinet and a minimum of 40 square feet for each suspect bassinet. Thus, with our recommendation for eight obstetrical beds there should be eight full-term bassinets with at least 192 square feet provided for them; and one suspect bassinet with at least forty square feet allocated in a separate nursery for its specific use. In addition, a utility and examination area is needed for the full-term nursery and a small examination and work area should be provided within the suspect nursery. According to our space study, the present nurseries have more than enough space to meet current and future needs. Two full-term nurseries now available have about 224 square feet apiece plus space allocated for utility and examination areas which are conveniently located between these nurseries. In addition to these facilities there is an adequate suspect nursery.

62. In conclusion, in relation to our planning concept we suggest that the nurseries be left basically intact.

Central Supply Department

63. The central supply department is currently located on the second floor of the 1953 structure and is convenient to the service elevator and the nursing units. Also included in the space study of this department is the solution storage room in the basement of the 1953 structure and the equipment storage rooms in the basement of the 1923 structure. Taking all the areas into consideration, we find that the department has approximately 63% of the space needed for now and in the future. This space shortage is primarily related to the lack of work area.

Exhibit No. 20—Continued

Furthermore, there is inadequate space provided for the administrative functions of the department. Currently, the director of the department has an office area which is not satisfactorily separated from the work area.

64. With additional work area, activities such as instrument and linen packing which are now done in the operating and recovery suite and the labor and delivery suite could be centralized in the department for a more efficient operation. Our proposals call for the department to expand at its present location.

Pharmacy

65. The pharmacy is located on the third floor of the 1923 structure and as such will have to be replaced in light of our recommendation to remove this building. Since no drug compounding is currently done or is anticipated, the concept of providing only storage space for the dispensing of drugs is sound. We suggest that approximately the same amount of space be provided for the future pharmacy as the present one now has. Furthermore, we suggest that the service be located in an area adjacent or at least near central stores and receiving. Such an arrangement will make for a more efficient flow of supplies with reduced man-hours spent traveling between the pharmacy and receiving and central stores areas.

Dietetics

66. Included in this category are the kitchen, storage areas and dining areas – which include the Sisters' dining facilities on the third floor of the 1923 structure. While the space allotted to the department as a whole is more than adequate for current and future needs, there are specific areas which lack sufficient space, primarily the employees' cafeteria. Furthermore, with the food for the cafeteria being supplied by the main kitchen, we note a poor functional relationship between the two due to their physical separation. The same situation also applies to the Sisters' dining facilities. These situations can be overcome by relocating the chapel to an area within the space allotted for administrative functions in our proposals. In turn, the cafeteria and Sisters' dining facilities could then be relocated to the area vacated by the chapel. With the dining areas located as proposed, there will

be an effective and efficient work flow between the kitchen and dining areas due to their proximity.

67. Besides the above inadequacies, we note that the hoods over the cooking ranges and ovens are not equipped with a fire extinguishing system or heat-actuated fan controls. However, the kitchen is satisfactorily located since it is easily accessible to the service elevator and the dietary receiving area, and the department is relatively modern. Its space problems can be remedied with relative ease; therefore, we suggest that the kitchen remain where it is but that the dining areas be relocated as described above.

68. These comments are based on the premise that the hospital will continue to operate in a similar manner and will not implement a convenience-food system to a significant degree. Basically, a convenience-food program entails less food preparation area and equipment but warrants additional storage space for the convenience foods. We suggest, then, that an effort be made to keep the department as flexible as possible so that, if feasible and desirable, a transition from the present food service operation to a convenience-food operation could take place with little difficulty.

Laundry, Linen and Housekeeping

69. According to our space standards the total space assigned to the laundry and linen areas is adequate. Housekeeping areas, on the other hand, are deficient in space. The location of the laundry is satisfactory since it is close to the service elevator. Furthermore, while the linen room is on the opposite end of the corridor from the laundry, our proposal calls for its relocation to an area adjacent to the laundry. With this arrangement the transfer of clean linen from the laundry to the linen room will be made more efficient. Also, since we recommend that the 1923 structure be removed, the storage areas for the laundry will have to be replaced. These can be relocated in an area adjacent to the laundry as indicated by our proposals.

70. Some of the more specific inadequacies relating to the laundry and linen facilities follow:

Exhibit No. 20—Continued

a. The linen chutes, which are located in the corridor of the 1953 structure leading to the 1923 structure open onto the corridor. Service openings to chutes should be located in a room or closet specifically designed for this purpose.

b. It was reported that ventilation in the laundry and linen rooms is poor.

c. It was reported that there is a problem in controlling lint in both the laundry and linen rooms.

d. The office area for the director of the laundry, linen, and housekeeping services does not provide sufficient privacy.

71. As in other recent consultations, we suggest that you plan flexibility into the laundry so that a change in the laundry operation will not drastically disrupt the service. We mention this since there has been a trend toward the use of disposables in hospitals – more and more items are being provided in disposable form. It seems evident that research will improve these products, and mass production will reduce their unit cost to the extent that hospitals will find it more economical to use these items than at present. Furthermore, automated equipment is now being marketed that permits a single handling of linen for the complete processing function. As these innovations gain acceptance, there will be a totally new approach to the design and space needs of a hospital laundry.

72. Housekeeping lacks adequate space for the storage of its supplies and equipment. Storage spaces are currently decentralized throughout the basement of the 1923 structure. As these areas are replaced in conjunction with the removal of the 1923 structure, they should be centralized. Another major housekeeping-related deficiency of the hospital is the fact that the second- and third-floor nursing units of the 1953 structure and the first-floor units of the 1923 structure are without janitor closets. Currently, hoppers in the soiled utility rooms or hopper rooms are used to fill utility pails and as a receptor for the dirty water from them. A janitor closet large enough to accommodate the storage of the housekeeping supplies and equipment needed to maintain the units and equipped with a floor receptor or floor sink should be provided on each nursing unit.

Exhibit No. 20—Continued

Purchasing and Central Stores and Storage

73. The total space afforded these areas is below our standards — about 89% of the space for current and future needs is being provided. Desirably, planning standards indicate a need for 20 square feet of central stores and storage per bed. It is sometimes contended that as more sophisticated inventory policies are implemented, reductions can be made in relation to this planning standard. However, the increasing use of disposable items and the resultant impact on central stores and storage areas lead us to a contrary conclusion. Therefore, we do not deviate from the projected need of 20 square feet per bed.

74. In relation to our recommendation to remove the 1923 structure, the storage areas in the basement of this building should be relocated to an area adjacent to central stores. Also affected by the removal of the 1923 structure will be the present entrance used for receiving (the former main entrance to the 1923 structure). Our proposals call for a receiving dock to be built on the first-floor level in the area where the 1923 structure connects with the 1953 structure. The receiving facilities, originally designed adjacent to the kitchen, are inadequate since the ramp from grade level to the basement is too steep and no platform is provided to ease the unloading of supplies and equipment from delivery trucks. Furthermore, the location of this receiving entrance is unsatisfactory since the delivery trucks using it tend to block the ambulance driveway.

Plant Operation and Maintenance

75. Although the maintenance shops have more than adequate space for present and future needs, they are located in a building which is separate from the main hospital complex. The Maintenance Building is located off Center Street to the rear of the 1923 structure. Furthermore, stairs must be traversed in order to reach the maintenance shops which are above grade. This situation is not only inconvenient in relation to the transporting of equipment and furniture needing repair from the hospital building to the Maintenance Building area, but it precludes the moving of larger pieces of equipment and furniture to the shops for repair.

Exhibit No. 20—Continued

76. Located in the Maintenance Building is a 40 kw. automatic switchover generator. It appears that the emergency electrical service provided by the generator supplies electricity to the necessary circuits as described in Section 824 of the U. S. P. H. S's manual: General Standards of Construction and Equipment for Hospital and Medical Facilities.

77. Two boilers, whose maximum working pressures are 160 pounds per square inch, are located in the boiler room which is adjacent to the laundry in the basement of the 1953 structure. It was reported that one boiler not operating at capacity can service the entire hospital on the coldest days of the year. This complies with our standard which calls for one fire boiler to act at all times as a back-up in emergencies.

78. Our proposals provide maintenance shop space in the basement of one of our proposed new additions. This arrangement would eliminate the inadequacies of the shops as described above.

Central Personnel Facilities

79. More than enough space to meet current and future needs is currently provided for central personnel facilities. However, the male and female lounge and locker areas in the basement of the 1923 structure will need replacing because of our recommendation to remove this wing. The male and female lockers and water closets in the basement of the 1953 structure, however, are adequate. Our proposals call for the personnel facilities in the 1923 structure to be relocated adjacent to those in the 1953 structure, thus centralizing them. We recommend centralized lounge, toilet, and locker facilities for departments such as dietetics, housekeeping, laundry and maintenance since this group of employees is generally expected to be uniformed. By centralizing these facilities their duplication is minimized and their usefulness is maximized.

On-Call Rooms

80. Currently, on-call facilities consist of a bed which has been placed in the doctors' lounge and locker room in the labor and delivery suite plus a bedroom located on the third floor of the 1923 structure. Since the lounge and locker room was not designed with enough space to accommodate a bed and since we have called for the removal of the 1923 structure we have recommended an on-call room on the third floor of the 1953 structure.

Exhibit No. 20—Continued

SMC 3-1

OTHER PLANNING FACTORS

1. At this point we will attempt to conceptualize the acute care program which we feel St. Mary's Hospital should develop. We will also discuss other health services which should be considered in future planning and the extent the hospital should commit itself to each.

2. Historically, the emphasis in general hospitals has been on the expansion of acute, short-term service. Pressures of demand from both community and medical staff have consumed a high percentage of available financial resources. Shortages of acute beds, availability of Hill-Burton and related financing, community interest, and demand for acute services have relegated other programs to second priority. Times are changing, however, and certain factors suggest a more active participation in new programs:

a. The philosophy of hospital services to the community is broadening.

b. The interests of medicine are changing, with increasing emphasis on total medical services.

c. The economics of hospital care have been a source of national concern, with spiraling costs raising questions as to the most effective method of meeting need within a broad spectrum of community services.

d. Community pressures are focusing on the evident imbalance of facilities and services between acute and other hospital-oriented services.

3. Priorities for construction must always focus attention on eliminating deficiencies and meeting the hospital's primary obligation to the community. However, it is necessary to consider the long-range services which may be needed and the impact of board decisions on all planning.

4. The first grouping of programs to be considered is related to the concept of progressive patient care which has received much recent attention in hospital literature. The total concept involves divisions of patient care by degree of illness and type of nursing care within the hospital, with coordinated extension of these services to

Exhibit No. 20—Continued

extended and long-term care facilities, and outpatient and home care. These divisions include: intensive care, intermediate care, minimum care, extended and long-term care, outpatient care, and home care.

Intensive-Coronary Care

5. The hospital currently has no nursing areas assigned for the specific use of patients needing intensive or coronary care. Patients needing close observation are normally assigned to rooms proximal to the nurses' station. However, when a patient requires constant observation and nursing care, he is assigned a private nurse. This arrangement exists primarily because of the shortage of registered nurses in the area. With the limited number of these nurses, the hospital cannot justify staffing a separate intensive-coronary care unit. Since this situation is expected to continue, we feel that the present method of caring for the seriously ill should be continued. Specifically, we suggest that these patients be assigned to a room directly adjacent to the nurses' station. Preferably, it should be accessible directly from the station. Furthermore, the wall between the nurses's station and the room should be partially filled with glass to afford the adequate visibility of the patient. Besides these features, life supportive and monitoring equipment should be stored in close proximity to the room to permit quick accessibility.

6. In the event that local nursing shortages subside we provide you with the following information relative to our planning concept for an intensive-coronary care unit.

7. Our rule of thumb planning standard for such beds is 5% - 7% of total adult medical-surgical beds. However, if medical policies which have a significant effect on planning should change — such as length of stay in coronary care — these percentages may need adjustment.

8. The design of these units has undergone some changes which have improved upon facilities planned a decade ago. Our design concepts call for:

a. Patients assigned to individual cubicled areas, while maintaining visibility throughout the patient areas and nurses station.

Exhibit No. 20—Continued

b. Supportive areas, i. e., storage for special equipment, clean and soiled utility, immediately available.

c. Oxygen and suction available to each patient.

d. Nurses station, which includes the charting area and nurses toilet, centrally located.

e. Supplies delivered to the unit so that the nurses do not have to leave the area.

f. Patient toilets conveniently available.

g. Adequate waiting area for relatives.

h. On-call space in immediate proximity.

9. We are seeking the separation of cubicled areas with appropriate environmental control; visibility throughout the patient areas and from the nurses station; and necessary utility, service and supporting areas.

10. There is sometimes a tendency to think of, and plan, a coronary care unit as a separate entity. We concur in the need, but believe that with the design features described above there is adequate separation of patients on the basis of specific medical or surgical conditions. If we then consider the design in terms of multi-bed modules, there can be assignment of sections to either coronary or intensive care. Adjacency provides flexibility for census fluctuations, and the total operation can be under the administrative umbrella of an ICU-CCU supervisor. There is a need for both separation and interrelation of these sections.

11. Finally, there is sometimes the temptation to develop an intensive care section adjacent, or close, to the recovery room. We oppose this concept for the following reasons:

a. The recovery room experience is a short emergency episode while intensive care may last several days.

Exhibit No. 20—Continued

b. The recovery room is oriented to anesthesiology while ICU-CCU is nursing oriented.

c. The recovery room is a surgical unit, while we believe in centralization of surgical and medical services in the ICU-CCU.

d. ICU-CCU introduces possible infection in the operating room area from visitors, etc. Conversely, surgeons and anesthesiologists should not be tempted to enter ICU-CCU in operating room dress.

e. Nursing and physician assistance is more readily available at night when the unit is not isolated.

Intermediate and Minimum Care

12. In planning future intermediate care nursing units we have provided a total of 93 beds in our proposals. These beds are distributed among a 51-bed medical-surgical unit; a unit with one nurses station and nursing service core area, but which is designed for 24 medical-surgical and/or extended care beds and 10 pediatric beds; and an 8-bed obstetrical unit.

13. There are features relative to our designing of the units which need explaining. As described in a previous section of the report, we suggest that the 1923 structure be removed because of its nonfire-resistive construction. Thus, all the beds in this building will have to be replaced. With this planning premise, we have used the 1953 structure as the basis for the hospital's future physical development. The second floor of this structure currently accommodates a 31-bed medical-surgical unit. Through the remodeling of this unit and the addition of a wing to the southwest and southeast of the 1953 structure, we have been able to expand the size of this unit to our proposed 51 beds — all of which are designated as medical-surgical beds.

14. Moving to the third floor of the 1953 structure, we find that while it now has only 10 obstetrical beds and 8 beds assigned for use by clean gynecological patients, our proposals call for its expansion to include one unit with 34 beds and another unit with 8 beds. The increase in this unit's size is accomplished by the above-mentioned wings added to the 1953 structure and through the enclosure of the roof at the southern end of the building.

Exhibit No. 20—Continued

15. Our concept of the planning of the nursing units on this floor is somewhat unique. Except for a few essential physical changes and the changes in the bed complement, we have left the obstetrical-gynecological unit intact. We suggest, then, that it be used primarily as an obstetrical unit in the future and have its own nursing staff and nursing service facilities. However, should the obstetrical census decline, clean gynecological patients could be admitted to the unit. On the other hand, should there be a need for more obstetrical beds the patient rooms immediately adjacent to the unit could be utilized. This flexibility will accommodate census fluctuations without the need to overextend the size of the obstetrical unit.

16. Lastly, through the use of design techniques, we have provided a unit with a total of 34 beds adjacent to the obstetrical unit. This unit will be capable of servicing pediatric, extended care (more will be said about this level of care later on in this section of the report), and adult medical-surgical patients from a single nurses station and without the need to duplicate nursing service facilities such as utility areas, pantries, lounges, etc. This has been accomplished by providing the proposed expanded area of the present third floor and the southwest addition to this floor with the necessary facilities as required by Medicare legislation for extended care units. Since these requirements are greater than those for a typical medical-surgical unit the unit automatically meets federal standards for medical-surgical care. Thus, depending on the circumstances, this section of the unit can be utilized entirely for extended care or medical-surgical patients — it can also be used by both types of patients at the same time.

17. As for pediatrics, we propose that it be accommodated in the southeast addition to the third floor. With this arrangement there is also the capability of medical-surgical and/or extended care patients to utilize this area as the census dictates.

18. In planning these units we attempted to integrate as many nursing units as possible in order to get larger units. We have been successful in this goal insofar as we have accommodated essentially the same number of beds in three units rather than four — the current number. We feel that the following advantages are inherent in our planning strategy:

Exhibit No. 20—Continued

a. There is a conservation of professional personnel time. The hospital could operate with fewer registered nurses, with adequate licensed practical nurses and back-up service from nurse aides.

b. With small nursing units, a fluctuation in patient census has a greater impact on nursing personnel, with periods of high or low occupancy affecting the hours of patient care per nurse to a greater degree than when units are combined as much as possible.

c. There are also more available personnel per unit which makes better coverage of the total unit possible, in the event of an emergency or absenteeism.

d. There need not be duplication of facilities such as nurses stations, utility rooms, treatment rooms, solariums, etc. Some areas might need to be slightly larger but there is an economy in construction and in the reduction of duplication of equipment.

e. In smaller units head nurses become involved in bedside patient care, which prevents the development of unit management as a full-time job. This would be less prevalent on the units as we have designed them.

f. With the larger units there is a reduction in their number, contributing to better control of supplies and inventory.

g. There will be fewer stops for doctors, with fewer people to be contacted regarding the care of their patients.

h. Food service can be improved.

i. There will be a volume of work to justify the hiring of competent clerical help.

j. The nursing program can be improved, by providing:

(1) Better supervision.

Exhibit No. 20—Continued

(2) Uniformity of procedures.

(3) Standards of supply and equipment.

(4) Improved orientation.

(5) More constant personnel patterns.

k. There is a greater capability to accommodate census variations for the various inpatient services.

19. All factors are important, but the overriding consideration is the use of the most expensive commodity — people.

20. Minimum or diagnostic care has had varying degrees of success, and there seems to be an inverse correlation with distance and utilization. For example, the primary success has been in such facilities as Veterans Administration hospitals, where convalescent care and great distance to patients' homes prevails; in major centers, such as the Mayo Clinic, where difficulties of travel from the patients' residences are substantial; or where there have been guiding forces in both medicine and administration to create a demand.

21. In more localized service areas we believe this pattern may partially represent an economic accommodation to provisions of hospital insurance coverage. As these provisions change to permit greater use of diagnostic facilities on an outpatient basis, will the demand be reduced? Also, does it make sense to provide a completely separate unit in a period of potential change?

22. In any event, we do not support the total concept of progressive patient care, with the constant movement of patients through several units within a relatively short period of time. Assignment of patients with selected types of nursing needs, and possibly preoperative care, to a specific nursing unit might be appropriate, but we would avoid transfer near the end of acute hospitalization merely because of some theoretical economies.

Extended and Long-Term Care

23. It is important to identify, with greater precision, specific needs for extended and long-term care. Needs for services

Exhibit No. 20—Continued

vary. Lack of an accepted definition results in a wide variation of planning bases. Therefore, there must be differentiation within the complex of services needed. Our attempt to define the terms follows:

a. Extended Care - Care of patients who can best benefit from skills and facilities available within the general hospital. The program must be of a dynamic nature and emphasize rehabilitation or definitive medical care and relatively early discharge. A unit of this type cares for patients who can derive positive benefit from the hospital's services including skilled nurses and physicians. One of the purposes of the unit is to free acute medical and surgical beds for use by more acutely ill patients, while also providing a continuing program of specialized care, on a short-term basis, to patients who need special facilities.

b. Long-term Care - Care of patients requiring an institutional nursing or boarding home setting after their conditions are stabilized or during terminal illness. There are also gradations of long-term care to consider, such as for those patients requiring skilled nursing care under medical supervision as against those requiring mainly personal attention and routine bedside care, or those in need of minimal care in a controlled unit.

24. We then proceed to the specific consideration of needs for each type of service in your hospital.

25. Extended Care - While the hospital service area is currently without any extended care facilities, we note that in recent years many physicians, hospitals, and community and government agencies have awakened to the long-neglected needs of the extended care patient. This has come about, in part, as a result of the following factors:

a. The number of people over 65 years of age is increasing and, while the need for extended care is not limited to that age group, there is a strong correlation between longer hospital stays, older age, and potential for transfer to extended care.

Exhibit No. 20—Continued

b. Advances in medicine have provided us with methods for slowing or arresting the development of some degenerative conditions hitherto relegated to the progressive and intractable category.

c. There has been recognition of the need to provide a balance of care in the community and to fill the existing gaps in the overall spectrum of services.

25. Most general hospitals have provided only acute care facilities in the past and have depended on nursing homes to provide the often-required next step. Generally, there have been no gradations in between. Where the need for rehabilitative care has been recognized and the facilities available, it frequently has been provided in acute care beds. The continual increase in patients requiring rehabilitative care makes it desirable that facilities be provided which are suited to their use and do not infringe upon the needs of acute care patients.

26. Now that federal funds are being made available for construction and operation of extended care units, it is becoming more feasible for general hospitals to actively plan inclusion of this category of care within their total programs.

27. As for the scope of extended care that you, as a general hospital, should strive to provide, we make the following comments:

a. Freestanding nursing homes will continue to provide the bulk of care for stabilized elderly, infirm people who need little more than a physician's occasional examination and custodial nursing care.

b. Chronic or long-term hospitals are probably best suited to handle those patients whose conditions are both chronic and unalterably degenerative.

c. The general hospital extended care unit should be concerned primarily with patients who can best benefit from the skills and facilities available within the hospital. The program must be of dynamic nature with emphasis on rehabilitation or definitive medical care and relatively early discharge.

Exhibit No. 20—Continued

28. If this concept is accepted, it follows that the need is directly related to the acute care program of St. Mary's Hospital, and the type of patients who are admitted and who would benefit by an extended care program. In terms of physical plant relationships, there should be direct connection between the extended and acute care units to permit movement of patients and provision of services without going outside the building or buildings involved.

29. Also implied by the above statement is the fact that extended care services are offered subsequent to a period of acute care; entry to this service then becomes a matter of patient transfer rather than outside admission. Just as extended care protects the use of acute care beds, so must it be protected against the congestion which would result from admitting the stabilized or terminal patient who requires nursing home type care. The use of this unit should also be subject to the supervision, standards and review mechanisms of the medical staff.

30. What are some of the advantages of a hospital-oriented extended care unit?

a. Physicians are available in case of emergency and for continuing care.

b. The general hospital has overall nursing supervision and a more constant supply of qualified nursing personnel for patients under the supervision of the medical staff twenty-four hours of the day.

c. All treatment facilities of the acute general hospital are immediately available.

d. Duplication of expensive facilities can be avoided for the community.

e. More specialized services, such as dietetics and physical medicine, are available.

f. It provides a greater flexibility of bed use, with ready transfer possible between the acute and convalescent sections of the hospital.

Exhibit No. 20—Continued

31. It is also important to emphasize that you — as responsible hospital leaders, and we — as planners — must continue to find new and better ways of providing necessary services in the most effective manner. These services must benefit the patient and conserve financial resources, and do so with the most efficient staffing patterns. One rule of thumb guide is that the rate structure for a hospital's extended care program can be estimated at between 60% to 66-2/3% of acute care hospital costs; nursing home care will approximate 60% of extended care costs.

32. We are, in effect, tying this concept of extended care to acute care needs. This is based on some recent studies of selected hospitals which have shown that approximately half of all patients who remain in a hospital for 21 days or longer could be cared for in an alternate type of accommodation. This point is further illustrated by an analysis we did of all patients who remained in St. Mary's for 21 days or longer for the year 1968. The results indicated that approximately 20% of the total number of patients cared for that year could have benefited from an extended care program.

33. While we are convinced that an extended care program should be implemented by the hospital, our planning decisions were influenced by concern for the ability of the hospital and community to finance such a program and the uncertainty as to whether the abnormally low utilization patterns that the hospital is now experiencing in relation to its adult medical and surgical services will reverse themselves in the future. Our final decision, then, is to design a 24-bed section of a nursing unit so that it will conform to federal standards governing the construction of extended care facilities. (This is explained earlier in this section of the report.) The 24-bed section will also be available for use by medical-surgical patients. Thus, depending on the prevailing circumstances, the beds at a given time may be used entirely by extended care or medical-surgical patients, or there may be a mixture of both types using them.

34. Long-term Care - Other than the 33-bed long-term care unit (geriatric unit) operated by St. Mary's, there are no other such facilities in the hospital service area. Thus, in light of a 1968 estimate by the State of Illinois Department of Public Health of a need of 75 long-term care beds for Alexander and Pulaski Counties alone, there appears to be a shortage of such beds in the area.

35. We do not, however, suggest that the hospital commit itself to a program of providing the entire number of long-term care beds to meet this theoretical need. If such a program were instituted

Exhibit No. 20—Continued

it might have a deterrent effect on the planning of your primary responsibilities through the dilution of finances and/or board interest. Furthermore, we note that the economic deterrents in the operation of long-term care units have not been entirely removed. This, together with the fact that a large portion of the hospital's patients are medically indigent, could put the hospital in an uncomfortable financial position if it overextended itself in a long-term care program.

36. We are confident, however, that the implementation of our proposed extended care program will do much to help alleviate the theoretical need for additional long-term care beds. Thus, if the hospital continues to operate its long-term care program with the present number of beds, and adopts our proposed extended care program, health needs of the elderly in the area will be substantially met.

37. As for the physical facilities we propose for long-term care, we suggest that, in view of our recommendations to remove the 1923 structure, a 26-bed long-term care unit be provided on the second floor of the nurses home. This would involve relocating the Sisters' living quarters and remodeling the floor. Additionally we have proposed a tunnel connecting the hospital to the nurses home so that diagnostic and treatment facilities and services will be easily accessible. Since this tunnel would protrude above ground, we suggest that steps be taken to assure the closure of Cross Street. We feel that the closure would be feasible since it is not widely trafficked. Even more important, it is not a thru-street — it terminates at Cedar Street.

38. In summary, while we have outlined a program for your commitment in both extended and long-term care, we suggest that you make a thorough study of the demand for extended care and its effects on your overall utilization patterns. Also, as other agencies — private, non-private, or government — succeed or fail to pick up the long-term care responsibility, you can more logically evaluate your long-range involvement in this area of care.

Home Health Care

39. It was reported that a Sister, who is a professional nurse specially trained in home care, has recently begun to implement a home care program at the hospital. We fully endorse this effort and encourage its progress. In the hope that the hospital will benefit by our experience with such programs we have included the subsequent remarks.

Exhibit No. 20—Continued

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40. We note that the home care programs which have been in existence have had only varying success. Economic and social patterns, distance and density of population, soundness of sponsorship, and type of medical practice all have had effects on their success.

41. In the most simple context, home care is the provision of health care at home. The concept is based on a physician-directed and hospital-coordinated program involving a broad range of nursing and other diagnostic, therapeutic and social services related to the needs of a select group of patients who require continuing attention but not hospitalization or institutionalization. The hospital seeks out or provides the supporting service requested by the physician. It cannot be inferred that this can be a substitute for direct medical or hospital care when indicated, but its proponents suggest that it can further the retention of independence on the part of the partially infirm.

42. The focal points of any health care program are the patient and physician and no effort can be successful without medical staff interest. The benefits of such a hospital-based program are multiple:

a. To the patient - it can further the retention of independence on the part of the partially infirm, recognizing that such a program is not a substitute for direct medical or hospital care.

b. To the community - it uses professional services in the most effective manner, thus overcoming some problems caused by shortages of medical, nursing and paramedical personnel.

c. To the hospital - there is the image of a comprehensive community health center, generated by an interested medical staff and hospital which have associated to offer a continuity of service — both in-and outpatient — and finally, a home-oriented care service.

43. The hospital participation could extend to a variety of services which could include:

a. Nursing care and/or nursing supervision — this could be coordinated with the Tri-County Health Department's visiting nurse service.

Exhibit No. 20—Continued

b. Availability of hospital laboratory, radiology, and inpatient services.

c. Physical, occupational, and speech therapy.

d. Appliances, equipment, and sterile supply service.

e. Transportation service.

f. Homemaker-home health aid service.

g. Nutritional guidance.

44. Because of the relatively recent interest in this type of service, beyond the pioneer programs, there is no secure measurement of its potential. However, space needs in the hospital are nominal and thus there is no irrevocable commitment to single-purpose facilities.

45. Office space is required, a nurse, and a clerical assistant. The clerical assistant could easily be shared with other ongoing hospital activities. What is important is to have someone available at all times to handle home care business by phone or in person and to keep track of the necessary records and requests. The nurse preferably should have public health experience and teaching ability. (As was mentioned above, the hospital is fortunate to already have such a person.)

46. We are not inclined to be dogmatic about sponsorship of such a program. If it is more propitious to integrate your service with those of the Tri-County Health Department while operating from a hospital base, this could be satisfactory since efforts would not be duplicated. If a hospital program seems more appropriate, this would also be satisfactory. The important point is to have medical administrative supervision, (this is usually accomplished by an appointment from the medical staff of a doctor who participates regularly in program activity); a continuity of interest, and a hospital base for coordination of the program.

Physical Medicine

47. One of the services which has potential for considerable expansion is physical medicine. Community medical services have drastically changed in emphasis in recent years, providing an entire new scope of health service responsibilities related to rehabilitation

Exhibit No. 20—Continued

services. This would assume even more importance should you become committed to a program of extended care. As medicine changes, the need for restorative programs which will alleviate or reduce physical disability must expand.

48. Our second observation is that there is need for a comprehensive medical direction to the program. The nature of special services, such as physical medicine, requires that there be an initial medical staff interest and sustained medical direction. We recognize, however, that the small population base of your service area makes it impractical to expect to attract a physician specifically to head the physical medicine program. Thus, we suggest that an effort be made to plan jointly with other hospitals in the surrounding area to provide medical supervision for physical medicine, hopefully by a board certified physiatrist, adequate to meet the needs of the participating hospitals.

Mental Health

49. The Alexander Pulaski Mental Health Association has a facility, the Community Service Center, which is located on the first floor of the nurses home. On an agency, self, or physician referral basis the Center offers outpatient care primarily in the form of follow-up care, individual consultation, and supportive group therapy. We consider these services vital to the community, particularly in light of the marked trend away from traditional dependence upon inpatient institutionalization and toward a broad scope of coordinated services. We strongly encourage future cooperation between the Center and the hospital.

50. As for inpatient psychiatric facilities, we note that the prime source of this type of care for patients in your service area is in the state hospitals. No inpatient psychiatric facilities are available in the service area, although on rare occasions a manageable psychiatric patient is admitted to St. Mary's Hospital and put in a private room for a short stay — usually overnight — or until he can be transferred to a state hospital or other institution having psychiatric facilities.

51. Inpatient psychiatric programs center around strong direction and utilization of a medical staff complemented with a psychiatrist. The primary element, then, for such a program is a psychiatrist experienced in the inpatient management of psychiatric patients.

Exhibit No. 20—Continued

Since it would not be practical or reasonable to expect to attract a psychiatrist, considering the size of your service area, we suggest that you continue referring persons needing inpatient psychiatric care to other hospitals providing such services. The only provision you should make, as far as facilities are concerned, is a few rooms on a medical-surgical unit, with detention screens and greater emphasis on prevention of sound transmission to other areas by noisy patients. A viewing window in the door and special hardware and fixtures designed for use in psychiatric facilities should also be provided for these rooms. Their primary use as psychiatric facilities should be limited to the patient awaiting transferral. The rooms should be available for use by medical and surgical patients when not otherwise needed.

Public Health

52. The role of the hospital as a leader in community health education and health activities is a logical and desirable one. This is particularly true when there is, as in your case, only one acute care general hospital serving the area. The hospital with its medical facilities and skilled personnel provides a nucleus around which various health programs can be implemented. The hospital whose main role is directed towards the inpatient is complemented by the public health services provided primarily for people outside the hospital.

53. Locally, the Tri-County Health Department is filling this complementary role as it is responsible not only for the surveillance and control aspects of environmental sanitation but also for medical, dental, and public health nursing programs. The Health Department is presently based on the first floor of the nurses home. Included in the programs provided by the Health Department are:

a. Public health nursing.

b. Venereal disease control.

c. Rheumatic fever control.

d. Communicable disease control.

e. Poison control.

f. Tuberculosis control.

Exhibit No. 20—Continued

g. Prenatal clinics.

h. School health programs.

i. Crippled children's clinic.

j. Dental clinics and education programs.

k. Environmental sanitation.

54. The important planning factor in this case is that the hospital and Health Department strive to coordinate their programs so that each can complement the other. It is only through such efforts that health programs can be developed and strengthened and the inefficiencies of duplication prevented.

55. Also, we feel that the present location of the department is satisfactory; in fact we encourage such arrangements. With the substantial increase in the number and variety of health disciplines and the number and variety of individuals working toward a common community goal, inadequate intergroup communication, possible overlapping of effort, and confusion in the public's mind as to which community services are available, can easily occur. The centralization of these community health services, on the other hand, provides the hospital service area with:

a. A patient-centered approach emphasizing the common goal of these organizations.

b. An ease of interchange of thought between groups as to present programs and future plans.

c. A cooperative approach which will maintain full utilization of community resources.

d. A convenient location for the public in dealing with these groups.

e. A centralization of community educational activity for a more effective community approach.

Exhibit No. 20—Continued

Physicians Office Building

56. While we are aware that the city of Cairo owns property adjacent to the hospital's site which it intends to eventually use for a medical arts building, and that there currently appears to be little interest among the physicians on the hospital's staff for a physicians office building, we nonetheless make the following comments in the hope that they will be useful in your long-range planning.

57. The traditional patterns of outpatient care involve the physician and his patient in a private office setting; as hospital loyalties are established, this private practice has an obvious impact on the hospital involved — both in terms of patient admissions and physician participation in the total hospital program.

58. The changing needs of medical practice and its dependence on hospital resources have made proximity of offices to the hospital-based skilled staffs and essential complex equipment increasingly important. Also, the administrative and committee responsibilities of staff membership, along with the extent of continuing education commitments, are continually increasing because of standards established by the various accrediting bodies. Thus, there are many advantages to physician and hospital in the growing trend toward provision of physicians office buildings in close proximity to hospitals.

59. The advantages to the physician in a professional office building owned and operated by the hospital on hospital property can be summarized as follows:

a. Improved utilization and concentration of the physician's time, permitting increased productivity and income, with reduction of noncompensated driving time.

b. Services of colleagues readily available for informal discussion, consultation or referral.

c. Complete diagnostic facilities readily available, resulting in less need for physicians to invest in major equipment.

d. Greater accessibility to hospitalized patients, permitting more frequent bedside visits and better supervision of care.

Exhibit No. 20—Continued

e. Less difficulty in attending medical staff, departmental, committee and other meetings.

f. Convenience of visiting medical records department to complete medical records during free time between office appointments.

g. Greater ability to respond rapidly to inpatient emergency calls or calls for the emergency department.

h. Facility in arranging emergency admissions from the office, with patients more likely to consent to immediate admission since transportation is not a factor.

i. Number of cancelled office appointments reduced, since an emergency in the hospital may cause delay but seldom requires postponement to another day.

j. Increased prestige through association with the community health (medical) center.

60. Many of the above are also advantageous to the hospital; for example:

a. Bringing the physician to and keeping him near the hospitalized patient, making possible improved patient services in all clinical areas.

b. Increased supervision of personnel involved in patient care activities and more time devoted to their educational programs.

c. Improved utilization and increased potential of hospital diagnostic and ancillary facilities.

d. Increased availability of physicians for consultation.

e. Improved overall integration of health resources, avoiding duplication of facilities and personnel in some areas.

f. Hospital image in the community enhanced by a medical center concept.

Exhibit No. 20—Continued

61. Two groups of physicians will be interested in such office development. First, those on your staff who are not permanently or adequately located. Second, new physicians who begin practice in the area would also find such an arrangement advantageous; the availability of office space adjacent to the hospital will assist in attracting them.

62. The disadvantages of commercial, individual or multiple-physician sponsorship can be avoided. Commercial development, in the first instance, is related to the corporate profit motive which may not be in accord with the hospital's long-range interest. Individual ownership permits a dominant position which could be reflected in potential problems with the medical staff and its administration. Multiple-physician ownership has many difficulties of organization and subsequent adjustments as there are changes or deaths within the original sponsorship group. None offer the advantages of objective and orderly development. Therefore, we specify hospital ownership because:

a. The hospital as a corporate entity can assure continuity of ownership of the building, obviating difficulties in settling the interest of a part owner who dies.

b. Building management more likely to be understanding of physicians' needs.

c. Office space may be offered to all members of the medical staff in good standing and not be restricted to a privileged or "in" group.

d. Office building development can be based on hospital medical staff need, providing additional office units as demand increases.

e. Physicians, who are generally not skilled in business practice, need not spend valuable professional time on details of building management.

f. Hospital services, such as housekeeping and maintenance, can be extended to the professional building for greater efficiency, economy of operation, and better supervision of work force.

Exhibit No. 20—Continued

g. Availability of the hospital's professional services can avoid duplication of expensive equipment in the physicians office building.

h. Ownership by a non-profit corporation may obviate the payment of real estate taxes on the professional building in some localities.

63. Development of a professional office building should not be undertaken on the basis of a unilateral decision by the governing board. It should be planned in consultation with the medical staff and only after a suitable number of physicians have expressed interest.

64. Prior to surveying medical staff interest in such an office building, you should have preliminary sketches and a proposed location. These should be presented at a meeting expressly held to explore the subject. It would then be appropriate to send a letter and questionnaire querying staff interest.

65. In conclusion, we stress that the development of such a building should be separate from and without the benefit of public financing. Availability of loans is substantial and initial local commitments could well be a small percentage of total costs. Given these premises there obviously must be provision for amortization. Also, there could be a directed purpose for any profits which may arise, as initial financial commitments are reduced. Perhaps this could be related to medical staff expenses for education, travel or other such purposes, or for special equipment which might otherwise place an undue strain on the hospital operating budget.

Physician Recruitment

66. The practical problem involved in attracting physicians to your community is caused both by their limited availability and your rather marginal population base. This does not, however, imply that it is impossible to attract a reasonable representation of the physicians needed. It will however, require a diligent, positive campaign with specific steps outlined to attain your goals. We realize that there may have been past efforts to attract more physicians and certain specialists to the community, but you might consider the following as a guide for a structured recruitment program.

Exhibit No. 20—Continued

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67. The first task is to define and agree on the basic objective of recruitment in terms of numbers; namely, the balance of family physicians and specialists to serve the community best, and the type of specialists needed. Also to be considered are the age limits which are desirable, compatibility of interests, and other related matters.

68. The composition and age of a future medical staff are factors which are often neglected in present-day planning. It is suggested that you create a five-man ad hoc committee to study the problem, including: two physicians; two members of the advisory board and one person from outside the community, knowledgeable in health affairs and needs.

69. The committee should be charged with the task described above — determining how many new family physicians should be recruited; how many specialists, and what type; whether the community is large enough to support these patterns of care; will there be referrals, etc.

70. The ad hoc committee should send its recommendations to the medical staff and governing board identifying the number and types of men who should be actively recruited. This approach could be called "selective recruitment." Agreement should be reached through a joint conference committee.

71. A recruitment committee should be established with representation from the medical staff and advisory board. Efforts should be made to contact professors in selected medical schools whose instructional objectives include the preparation of physicians for areas such as yours. They might know which graduates are seeking a new location for their practice. A reprint of an article published in the September 1968 issue of Modern Hospital deals with the approach to recruitment, and is included on the next page for your reference:

Exhibit No. 20—Continued

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Medical Staff Forum *Anthony J. J. Rourke, M.D.*

Here are 10 questions staff applicants may ask

Selective recruitment of a staff physician requires not only specification of what the hospital is seeking in terms of age, training, field, and so on, but also specification of what the hospital has to offer and the ability to tell the right people. This process excludes applicants looking for a place to retire or those who have failed elsewhere.

There is no better first step for a recruitment committee than to try to put itself in the place of the prospective applicant and anticipate what questions he will ask.

Dr. Rourke

- Will I be welcomed by the medical staff or will I have to fight for a living the first few years?
- Is the town large enough to support my field?
- Do the medical staff, governing board and administrator think there is a need for my type of physician?
- What kind of town is the hospital located in – residential, industrial, college?
- Is the hospital progressive? What size is it? Is it accredited? Is it in old or new buildings? Does it have an intensive care unit, extended care facilities, an outpatient department, and postoperative facilities?
- Is there good schooling available for my children?
- What kind of recreational facilities does the town offer?
- What churches are present?
- How far is it to the large metropolitan centers?
- Is this an area of the country I can spend the rest of my life in?

These are the kinds of questions that should be answered by the recruitment committee before they are asked.

In recruiting specialists, one source of information is the directors of residency training in a specific field. There appears to be an ongoing contact between the directors and men who have served residencies under their guidance.

A letter should be addressed to each director outlining what you are seeking, why you believe your town can support such a man, and that the medical staff has endorsed the project. To give further evidence of agreement, the letter should be personally signed by the president of the medical staff, the president of the governing board, and the administrators.

Accompanying this letter should be a leaflet or folder with some top-grade photography and text which would hold answers to such questions as those listed above.

You may be seeking a man who is opening his first office. If so, the directors of training in the field know the men who are about to finish. You may be seeking a man with a few years of experience. These same directors of training know of former residents who would like to relocate.

Once the applications are received, be sure to invite the applicants and their wives to visit your town and hospital.

Keep in mind, however, that there is no formula for complete success in picking people, but that a selective process has a greater chance for success than the happenstance approach. ■

Dr. Rourke is a hospital consultant with offices in New Rochelle, N.Y.

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Exhibit No. 20—Continued

72. We also note the value of subsidy as an attraction in recruitment. Such an inducement is sometimes opposed by those "who made it themselves." But times are changing and this can be one additional bit of evidence that a new physician will be welcome. What form could this subsidy take?

a. There could be a three-to-five year guaranteed income with each year's subsidy at decreasing levels.

b. New physicians could be allowed to cover the emergency room on a fee-for-service basis, with appropriate medical staff policies.

c. Housing, automobile, office, or fringe benefits could be made available for a specified period.

73. It is as important to add to the number of physicians at St. Mary's Hospital in an orderly approach and to attain some balance of clinical interest as it is to add to hospital buildings.

Trusteeship, Ownership, and Planning

74. At this point we would like to comment briefly on the hospital's potential commitment to the recent findings of the Catholic Hospital Association's Task Force Committee regarding trusteeship, ownership, and planning.

75. The Committee's findings on trusteeship are quoted as follows:

"1. The board of trustees of a Catholic-sponsored health care institution is legally and morally bound to conduct the affairs of the corporation in the best interests of the patient, the public, the institution, and the sponsoring group.

"2. The board of trustees is responsible for every facet of hospital operation, including the quality of medical care provided.

"3. The board of trustees has the serious responsibility to appoint qualified physicians and to approve appropriate privileges.

Exhibit No. 20—Continued

"4. The board of trustees should appoint a qualified administrator.

"5. The board of trustees should give a report regularly of hospital operations to the publics they serve.

"6. Development of centralized services by a sponsoring group necessitates the involvement of boards of trustees of health care institutions with respect to providing these services.

"7. The board of trustees should have lay representation from the community served.

"8. Qualification for board membership applies equally to laymen and religious. Membership should reflect a diversity of talents such as knowledge of patient care, community health needs, governmental relations, finance, management, and religious values."

76. We note that the hospital has already taken a formidable step, through its appointment of an advisory board, in giving the local community the opportunity to voice its opinion in regard to the planning and operation of the hospital. This board is not responsible for the operation of St. Mary's nor does it have the power to execute policies; it is, nonetheless, a significant stepping stone in the formation of a board as envisioned by the Task Force Committee.

77. While we concur with the committee's findings, we also recognize the present social climate of the community. Therefore, we suggest that the hospital have as a goal the implementation of the above findings on trusteeship. However, the full realization of such findings should come about only after it has become evident that the thinking of the total community can be represented by the trustees. Regarding ownership, we list the following findings of the committee on this subject:

"1. Catholic-sponsored health care institutions are private corporations to be operated in the public interest as community health care facilities.

"2. Catholic-sponsored health care institutions must recognize the growing public accountability of all health care organizations.

Exhibit No. 20—Continued

"3. The sponsoring group and the health care facility are separate entities with distinct legal purposes and responsibilities.

"4. Health care facilities under Catholic auspices should be incorporated separately from the sponsoring group.

"5. The sponsoring group must define its objectives in sponsoring a health care facility. The degree of corporate control must be consistent with its defined objectives and with the local circumstances.

"6. Control by the sponsoring group may be exercised through the charter and bylaws of the health facility, through corporate membership, or through membership on the board of trustees.

"7. The securing of capital financing should be the responsibility of the health care institution. Any funds loaned to the health care facility by the sponsoring group should be secured by appropriate legal instruments."

78. Our only comment in reference to the above findings is that while it was reported that the Sisters' religious community has been moving toward local boards in the control of their hospitals, we suggest that the Sisters retain the right to select and appoint the auditor and the right to buy and/or sell property.

79. We conclude with the Committee's findings on planning:

"1. A board of trustees of a Catholic-sponsored health care institution must have a long-range plan which should be updated on a regular basis. Such planning should include the determination of community needs for services, financing, staffing, and facilities.

"2. Catholic-sponsored health care institutions have a continuing responsibility to participate with recognized agencies in the planning of personal health services.

"3. Members of the board of trustees, medical staff and administration of Catholic-sponsored health care institutions should seek involvement in community and regional health planning activities.

Exhibit No. 20—Continued

"4. Administration has a responsibility to keep the board of trustees fully informed of needs to be considered in developing plans for the institution.

"5. The sponsoring group should be periodically informed of the health care institution's plans by the board of trustees.

"6. Planning among Catholic-sponsored health care institutions within the context of community-wide planning is a sound practice.

"7. The religious congregation should have a definite plan for the assignment of its personnel to the health field."

80. The Committee noted that while planning will no longer be optional, but mandatory — thus limiting the autonomy of the individual institution — it will nonetheless offer a better way for Catholic-sponsored health care facilities to discharge their public trust. Furthermore, it was noted that planning agencies should not be fought but directed by the active participation of the members of the Catholic-sponsored health care facilities.

Exhibit No. 20—Continued

APPENDIX

TABLE 1

ANALYSIS OF RESIDENCE OF PATIENTS DISCHARGED 1/
1968

	1968 Estimated Population 2/	1968 Discharges	Admissions Per 1,000 Population 3/	Percent Distribution of Admissions
Total Weighted Hospital Service Area 4/	22,800	1,927	84.5	100.0%
Primary Area 5/	17,200	1,291	75.1	67.0
Secondary Area 6/	20,800	419	20.1	21.7
Out of Area	-	217	-	11.3

1/ Residence data is based on a 20% sampling of 1968 discharges for St. Mary's Hospital.
2/ Based on: a. Data as found in A Comprehensive Long-Range Development Plan, Delta Region, Illinois, 1967 for those areas in Illinois which are in the service area.
b. Our estimation and projections of past population trends for those areas in Missouri which are in the service area.
3/ Because of the insignificant variation between admissions and discharges, we refer to the rate as admissions per 1,000 population to permit a continuity in our use of terms and comparative analyses.
4/ Includes 100% of the primary area population plus that proportion of the secondary area population which equals the percentage relationship of the secondary area to the primary area (26.8%).
5/ Includes Cairo, Mounds, Mound City, America, Cache No. 1, Cache No. 2, Olmsted, Pulaski and Villa Ridge precincts.
6/ Includes Grand Chain, Olive Branch, Sandusky, Tamms, Thebes, Ullin, Santa Fe, Miller and Unity precincts in Illinois, and Ohio, St. James, and Tywappity townships in Missouri.

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TABLE 2

ACTUAL, ESTIMATED, AND PROJECTED POPULATION STUDY
1940 - 1985

	Actual 1/			Estimated 2/	Projected 2/			
	1940	1950	1960	1968	1970	1975	1980	1985
Weighted Hospital Service Area	32,593	29,476	24,076	22,800	22,900	23,900	26,000	31,700

1/ Source: Bureau of the Census, 1960 Census of the Population.

2/ Based on: a. Data as found in A Comprehensive Long-Range Development Plan, Delta Region, Illinois, 1967 for those areas in Illinois which are in the service area.

b. Our estimation and projections of past population trends for those areas in Missouri which are in the service area.

T2

Exhibit No. 20—Continued

TABLE 3

AGE DISTRIBUTION FOR ST. MARY'S HOSPITAL SERVICE AREA
ILLINOIS AND THE UNITED STATES
1960

	Under 5 Years	5 - 14 Years	15 - 24 Years	25 - 34 Years	35 - 44 Years	45 - 54 Years	55 - 64 Years	65 Years & Over	Total
Weighted Hospital Service area	10.7	20.3	11.8	8.5	10.5	11.9	11.2	15.1	100.0%
Delta Area	10.0	19.8	11.7	8.7	10.7	12.4	11.4	15.3	100.0
Illinois	11.2	18.6	12.6	12.7	13.7	12.1	9.4	9.7	100.0
United States	11.3	19.8	13.4	12.8	13.4	11.4	8.7	9.2	100.0

TABLE 4

INPATIENT UTILIZATION
1960 - 1968

	1960	1962	1964	1966	1968
Bed Complement	125	92	92	98	98
Medicine & Surgery	94	61	61	67	67
Pediatrics	21	21	21	21	21
Obstetrics	10	10	10	10	10
Geriatrics	-	33	33	33	33
Newborn	12	12	12	12	12
Patient Discharges	3,152	2,509	2,553	2,184	1,927
Medicine	1,022	752	870	880	755
Surgery	1,096	808	783	679	550
Pediatrics	473	376	457	281	359
Obstetrics	561	573	443	344	263
Geriatrics 1/	-	25	14	20	20 2/
Newborn	435	436	405	293	206

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TABLE 4 - page 2

	1960	1962	1964	1966	1968
Average Daily Census	60.9	55.8	58.7	51.6	48.6
Medicine	24.9	22.3	25.2	24.8	26.7
Surgery	24.3	21.8	21.6	17.7	13.3
Pediatrics	6.5	6.5	8.1	5.5	5.9
Obstetrics	5.2	5.2	3.8	3.6	2.7
Geriatrics 1/	-	23.9	28.8	27.1	29.7 2/
Newborn	4.3	4.1	3.7	3.2	2.2
Average Length of Stay	7.1	8.1	8.4	8.6	9.2
Medicine	8.9	10.8	10.6	10.3	12.9
Surgery	8.1	9.8	10.1	9.5	8.8
Pediatrics	5.0	6.3	6.5	7.1	6.0
Obstetrics	3.4	3.3	3.2	3.8	3.7
Geriatrics 1/	-	34.9	75.4	49.5	54.3 2/
Newborn	3.7	3.4	3.4	4.0	4.0

T4-2

TABLE 4 - page 3

	1960	1962	1964	1966	1968
Percent Occupancy	48.7%	60.6%	63.8%	52.6%	49.6%
Medicine & Surgery	52.3	72.3	76.7	63.4	59.7
Pediatrics	31.0	31,0	38.6	26.2	28.1
Obstetrics	52.0	52.0	38.0	36.0	27.0
Geriatrics 1/	-	72.4	87.3	82.1	90.0 2/
Newborn	35.8	34.2	30.8	26.7	18.3
Patient Days	22,282	20,369	21,469	18,852	17,777
Medicine	9,094	8,153	9,215	9,072	9,774
Surgery	8,907	7,942	7,895	6,463	4,859
Pediatrics	2,367	2,359	2,955	2,009	2,166
Obstetrics	1,914	1,915	1,404	1,308	978
Geriatrics 1/	-	8,723	10,553	9,897	10,854 2/
Newborn	1,588	1,484	1,365	1,186	815

1/ Fiscal years ending May 31.

2/ Eleven months ending April 30, 1968.

TABLE 5

OCCURRENCES OF OCCUPANCY
(May 1, 1968 - April 30, 1969)

Census	Days of Occurrence	Percent of Year	Census	Days of Occurrence	Percent of Year	Census	Days of Occurrence	Percent of Year
	Pediatrics - 21 Beds			Obstetrics - 10 Beds			Medicine & Surgery - 67 Beds	
0 - 1	36	9.9%	0 - 1	72	19.7%	26 - 29	8	2.2%
2 - 3	96	26.3	2 - 3	125	34.3	30 - 34	25	6.9
4 - 5	106	29.0	4 - 5	80	21.9	35 - 39	76	20.8
6 - 7	58	15.9	6 1/ - 7	38	10.4	40 1/ - 44	119	32.6
8 - 9	28	7.7	8 - 9	34	9.3	45 - 49	88	24.1
10 - 11	23	6.3	10 - 11	14	3.8	50 - 54 2/	37	10.1
12 - 13 1/	16	4.4	12 - 13	2	0.6	55 - 59	11	3.0
14	2	0.5		365	100.0%	60 - 61	1	0.3
	365	100.0%					365	100.0%

1/ 60% occupancy.

2/ 80% occupancy.

Exhibit No. 20—Continued

Exhibit No. 20—Continued

SMC T6

TABLE 6

CENSUS BY MONTH
(May 1, 1968 - April 30, 1969)

	Census 1/	Percent Variation From Average 2/
May 1968	52.3	+ 1.4%
June	56.0	+ 8.7
July	52.8	+ 2.4
August	45.8	-11.1
September	48.8	- 5.4
October	44.4	-13.9
November	53.2	+ 3.2
December	52.1	+ 1.1
January 1969	55.7	+ 8.1
February	54.7	+ 6.1
March	54.4	+ 5.5
April	48.4	- 6.1

1/ Excludes geriatrics.

2/ Percent variation computed with figures at two decimal places.

Exhibit No. 20—Continued

SMC T7

TABLE 7

SUMMARY OF SHORT TERM GENERAL HOSPITAL UTILIZATION
NATIONAL EXPERIENCE: 1958-1968 1/

Year	Admissions 2/		Patient Days 2/		Average Length of Stay
	Actual	Adjusted	Actual	Adjusted	
1958	125.2	123.6	956	948	7.59
1959	122.2	125.1	962	958	7.81
1960	127.6	126.1	980	968	7.60
1961	127.7	128.9	985	983	7.64
1962	130.8	131.1	1,011	1,002	7.64
1963	134.0	133.5	1,036	1,025	7.66
1964	135.8	135.9	1,063	1,049	7.75
1965	137.9	137.5	1,071	1,071	7.77
1966	138.8	138.2	1,108	1,111	7.98
1967	137.9	138.4	1,142	1,168	8.28
1968	-	139.9	-	1,220	8.35

1/ Source: Journal of the American Hospital Association Guide Issue, August 1, 1959-68.

2/ Expressed as rate per 1,000 population; adjusted by application of a three-year moving average to actual data.

TABLE 8

COMPARISON OF ST. MARY'S HOSPITAL
AND NATIONAL ADMISSION RATES
1960 - 1968

Year	Weighted Hospital Service Area Population	Discharges	Admissions Per 1,000 Population		St. Mary's Rate as Percent of National Rate
			St. Mary's 1/	National	
1960	24,076	3,152	130.9	126.1	103.8%
1962	23,757	2,509	105.6	131.1	80.6
1964	23,438	2,553	108.9	135.9	80.1
1966	23,119	2,184	94.5	138.2	68.4
1968	22,800	1,927	84.5	139.9	60.4

1/ Because of the insignificant variation between admissions and discharges, we refer to the rate as admissions per 1,000 population to permit a continuity in our use of terms and comparative analyses.

Exhibit No. 20—Continued

SMC T9

TABLE 9

ACUTE CARE BED PROJECTIONS
1970 - 1985

	1970	1975	1980	1985
Weighted Hospital Service Area Population	22,900	23,900	26,000	31,700
Admission Rate 1/	114.2	120.1	125.9	131.8
Admissions	2,615	2,870	3,273	4,178
Average Length of Stay				
Low 2/	8.3	8.5	8.7	8.9
High 3/	8.9	9.1	9.3	9.5
Patient Days				
Low	21,704	24,395	28,475	37,184
High	23,274	26,117	30,439	39,691
Average Daily Census				
Low	60	67	78	102
High	64	72	83	109
Beds				
Low	83	92	104	132
High	88	98	110	140
Consultant's Recommendation	85	95	105	135

1/ Computed at 80% of projected national rate.

2/ Computed at 100% of the projected national average length of stay.

3/ Computed at 107% of the projected national average length of stay.

TABLE 10

DEPARTMENTAL UTILIZATION
1960 - 1968

	1960	1962	1964	1966	1968
Laboratory Tests	37,809	38,399	42,105	57,454	41,747
Tests per Inpatient	12.0	15.3	16.5	26.3	21.7
Electrocardiograms	677	862	983	1,219	1,105
Radiological Activity	3,906	3,985	4,375	4,340	4,271
Radiological Procedures	3,906	3,948	4,364	4,329	4,264
Procedures per Inpatient	1.2	1.6	1.6	2.0	2.2
Therapeutic Procedures	-	37	11	11	7
Surgical Procedures	936	597	536	475	270
Major	343	268	215	161	103
Minor	552	312	308	304	160
Oral	41	17	13	10	7
Procedures per Inpatient	.30	.24	.21	.22	.14
Emergency Room Visits	861	1,175	1,656	2,200	2,829
Convenience	242	315	554	700	978
Emergency	619	860	1,102	1,500	1,851
Visits/1,000 Population	35.8	49.5	70.6	95.2	124.1
Deliveries	441	446	395	282	237

T10

TABLE 11

DEPARTMENTAL SPACE ANALYSIS
SUMMARY
(Approximate Net Square Feet)

Department/Function	Existing 131 Beds			Recommended 125 Beds			Percent of Need Met at 125 Beds
	1923 Building	1950 Building	Total	95 Beds	Add'l Space Needed for 30-Bed Long-Term Care Unit	Total	
Total	18,585	28,625	47,210	49,760	7,730	57,490	82.1%
Administration	1,635	2,450	4,085	3,980	-	3,980	102.6
Diagnostic & Treatment Services	-	6,360	6,360	9,710	-	9,710	65.5
Pathology	-	1,180	1,180	1,855	-	1,855	63.6
Radiology	-	1,130	1,130	2,140	-	2,140	52.8
Physical Medicine & Special Services	-	70	70	1,020	-	1,020	6.9
Outpatient Care Facilities	-	245	245	960	-	960	25.5
Operating & Recovery Suite	-	1,995	1,995	1,995	-	1,995	100.0
Labor & Delivery Suite	-	1,740	1,740	1,740	-	1,740	100.0
Nursing Units & Nurseries	13,325	8,045	21,370	20,420	6,000	26,420	80.9
Nursing Units	13,325	7,115	20,440	19,600	6,000	25,600	79.8
Newborn Nurseries	-	930	930	820	-	820	113.4
Service Departments	3,625	11,770	15,395	15,650	1,730	17,380	88.6
Central Supply Department	285	470	755	1,000	200	1,200	62.9
Pharmacy	495	-	495	430	50	480	103.1
Dietetics	1,060	2,790	3,850	3,165	400	3,565	108.0
Laundry, Linen & Housekeeping	590	2,205	2,795	2,900	200	3,100	90.2
Purchasing, Central Stores & Storage	165	2,555	2,720	2,665	400	3,065	88.7
Physical Plant & Maintenance	185	3,405	3,590	4,720	400	5,120	70.1
Central Personnel Facilities	650	345	995	650	80	730	136.3
On-Call Rooms	195	-	195	120	-	120	162.5

Exhibit No. 20—Continued

SMC T11-2

TABLE 11- page 2

	Existing			Recommended 95 Beds
	1923 Building	1950 Building	Total	
Total	18,585	28,625	47,210	49,760
Administrator	1,635	2,450	4,085	3,980
Public Areas 1/	-	1,305	1,305	1,150
Administrative Suite 2/	695	240	935	600
Nursing Offices	-	100	100	240
Fiscal Functions	-	630	630	820
Admitting	-	95	95	300
Medical Records & Medical Staff	940	-	940	760
Personnel Facilities	-	50	50	80
Janitor's Closet	-	30	30	30
Laboratory	-	1,180	1,180	1,855
Control Offices & Waiting	-	- 3/	-	340
Laboratories, Blood Bank & Drawing	-	760	760	850
General Utility & Storage	-	170	170	220
Morgue & Autopsy	-	250	250	345
Personnel Facilities	-	-	-	100
Radiology	-	1,130	1,130	2,140
Control, Offices & Waiting	-	150	150	640
Diagnostic Areas	-	480	480	770
Treatment Areas	-	165	165	-
General Utility & Storage	-	250	250	80
Film Processing, Files & Viewing	-	85	85	550
Personnel Facilities	-	-	-	100

Exhibit No. 20—Continued

SMC T11-3

TABLE 11- page 3

	Existing			Recommended
	1923 Building	1950 Building	Total	95 Beds
Physical Medicine & Special Services	-	70	70	1,020
Control, Offices & Waiting	-	-	-	140
Physical Medicine	-	-	-	600
Treatment Areas & Examining Rooms	-	-	-	240
Gymnasium	-	-	-	220
Hydrotherapy	-	-	-	40
General Utility	-	-	-	100
Special Services	-	70	70	280
General Utility & Storage	-	-	-	40
Electrocardiography	-	70	70	120
Pulmonary Function & Inhalation Therapy	-	-	-	120
Outpatient Care	-	245	245	960
Control, Offices & Waiting	-	-	-	300
Treatment & Examination Areas	-	245	245	560
General Utility	-	-	-	100
Operating & Recovery Suite	-	1,995	1,995	1,995
Zone 1	-	600	600	600
Operating Room, Scrub & Substerile	-	600	600	600
Zone 2	-	265	265	265
Cystoscopy, Scrub, & Substerile	-	-	-	-
Orthopedics	-	240	240	240
Darkroom & Controls	-	25	25	25

Exhibit No. 20—Continued

SMC T11-4

TABLE 11 - page 4

	Existing			Recommended
	1923 Building	1950 Building	Total	95 Beds
Zone 3	-	1,130	1,130	1,130
Work & Storage Areas	-	495	495	495
Control & Offices	-	100	100	100
Doctors Lounge & Lockers	-	270	270	270
Nurses Lounge & Lockers	-	90	90	90
Recovery Room	-	175	175	175
Labor & Delivery Suite	-	1,740	1,740	1,740
Delivery Rooms, Scrub & Substerilizing	-	610	610	610
Labor Rooms	-	220	220	220
Recovery Room	-	185	185	185
Control, Work & Storage Areas	-	225	225	225
Personnel Facilities	-	365	365	365
Doctors Lounge & Lockers	-	235	235	235
Nurses Lounge & Lockers	-	130	130	130
Fathers' Waiting	-	135	135	135
Nursing Units & Nurseries	13,325	8,045	21,370	20,420
Nursing Units	13,325	7,115	20,440	19,600
Patient Areas	8,115	5,880	13,995	13,700
Nursing Service Areas	5,210	1,235	6,445	5,900
Newborn Nurseries	-	930	930	820
Full-Term	-	445	445	280
Suspect	-	105	105	100
Work Areas, Examination & Storage	-	140	140	200
Formula Preparation & Storage	-	240	240	240
Central Supply Department	285	470	755	1,000
Pharmacy	495	-	495	430

Exhibit No. 20—Continued

SMC T11-5

TABLE 11 - page 5

	Existing			Recommended
	1923 Building	1950 Building	Total	95 Beds
Dietetics	1,060	2,790	3,850	3,165
Kitchen, Storage & Dishwashing	-	2,045	2,045	2,045
Serving & Dining Areas	1,060 4/	625	1,685	1,000
Offices	-	120	120	120
Laundry, Linen & Housekeeping	590	2,205	2,795	2,900
Laundry & Linen	165	2,205	2,370	2,300
Housekeeping	425	-	425	600
Purchasing & Central Stores & Storage	165	2,555	2,720	2,665
Purchasing & Receiving	-	145	145	145
Central Stores & Storage 5/	165	2,190	2,355	2,300
Record Storage	-	220	220	220
Plant Operations & Maintenance	185	3,405	3,590	4,720
Maintenance Shops, Storage & Office 6/	-	-	-	720
Boilers & Mechanical	185	3,405	3,590	4,000
Central Personnel Facilities	650 7/	345	995	650
On-Call	195	-	195	120

Exhibit No. 20—Continued

SMC T11-6

TABLE 11 - page 6

1/ Includes chapel.

2/ Includes personnel office and social service office (opposite personnel office).

3/ Since the waiting area is in a corridor, we have not included it in this space analysis.

4/ Includes sisters' lounge and dining area on the third floor.

5/ Includes oxygen storage room in the basement.

6/ The 2,400 square feet in the maintenance building which is allocated for shops, storage and office space is excluded from this analysis.

7/ Represents female and male lounge in the basement.

Exhibit No. 20—Continued

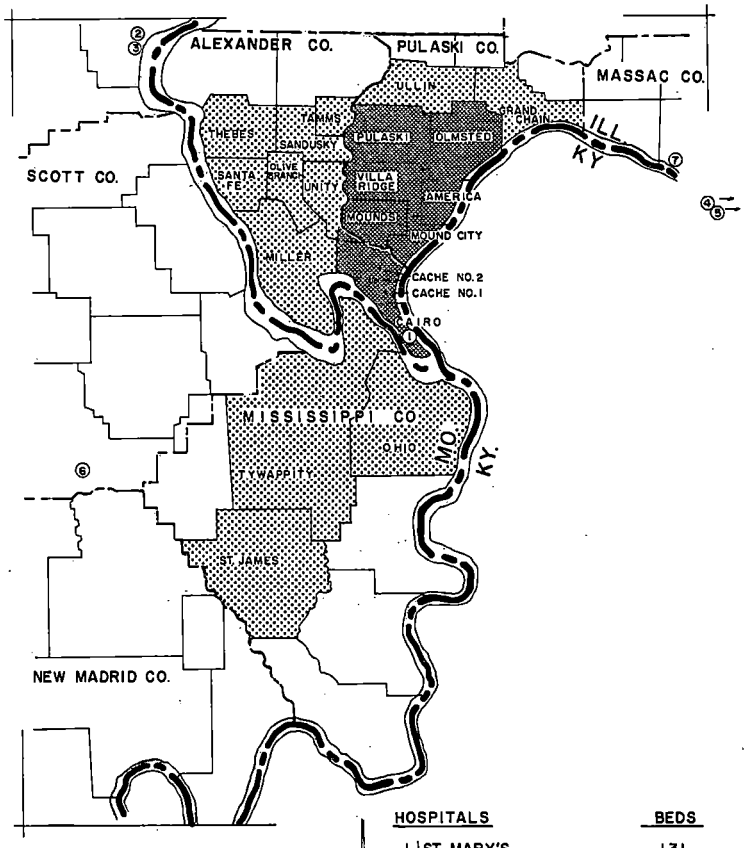
CHARTS

Exhibit No. 20—Continued

CHART - I

SAINT MARY'S HOSPITAL

HOSPITAL SERVICE AREA



	ADM./1000 POP.
TOTAL	84.5
PRIMARY AREA	75.1
SECONDARY AREA	20.1

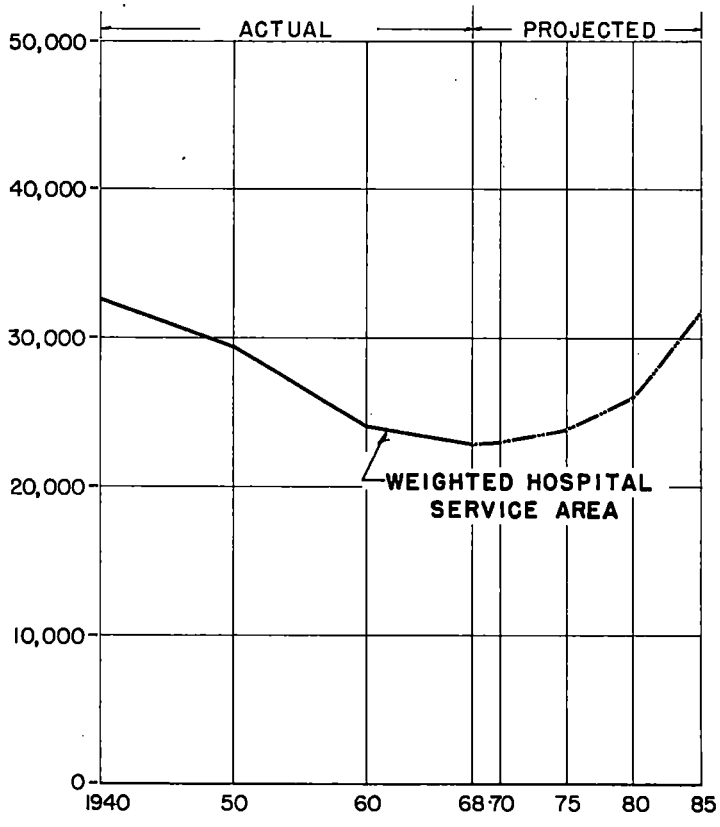
	HOSPITALS	BEDS
1	ST. MARY'S	131
2	ST. FRANCIS	122
3	SOUTHEAST MISSOURI	185
4	LOURDES	134
5	WESTERN BAPTIST	197
6	MISSOURI DELTA COMMUNITY	110
7	MASSAC MEM.	60

Exhibit No. 20—Continued

CHART - 2

SAINT MARY'S HOSPITAL

POPULATION AND POPULATION PROJECTIONS 1940 - 1985



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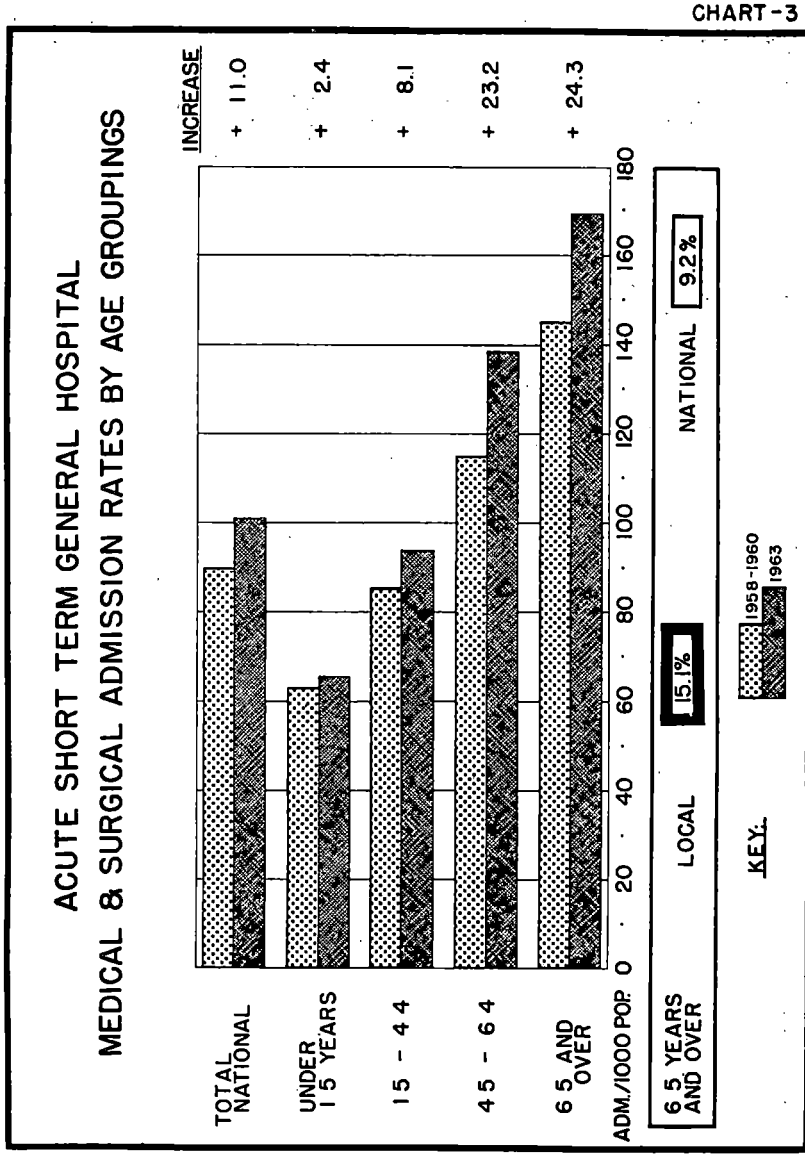


Exhibit No. 20—Continued

CHART - 4

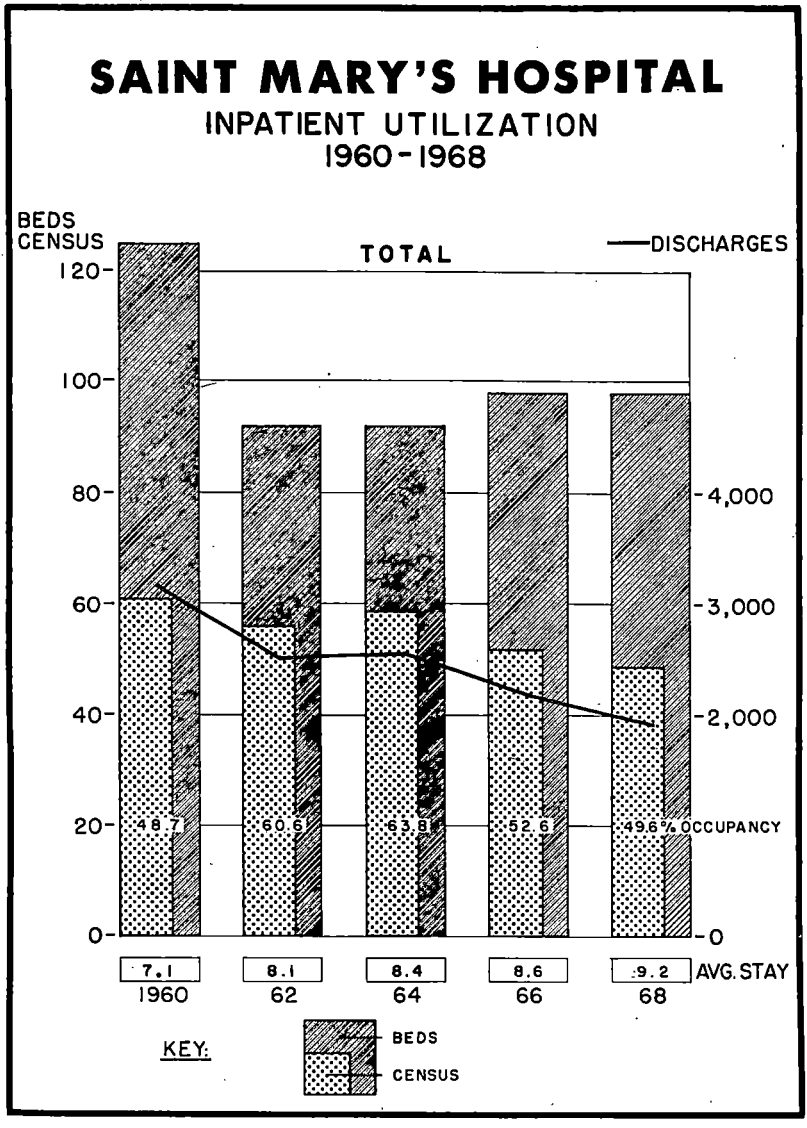


Exhibit No. 20—Continued

CHART-5

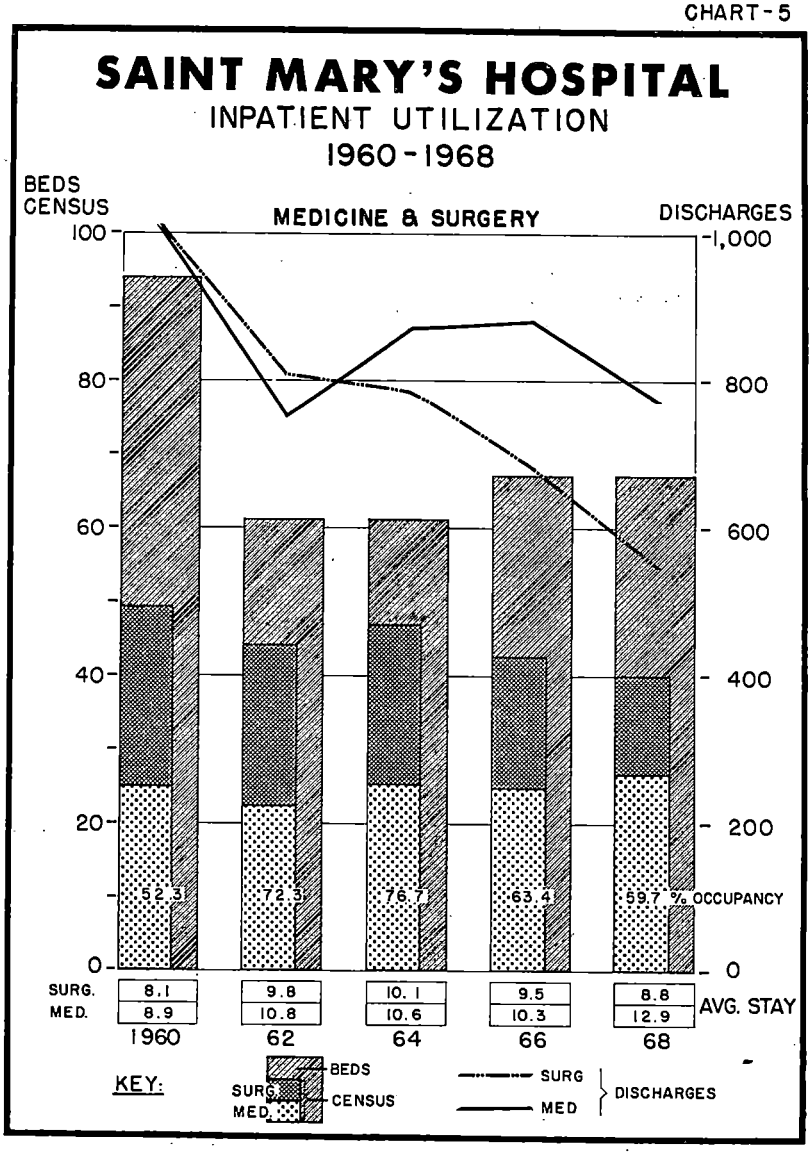


Exhibit No. 20—Continued

CHART-6

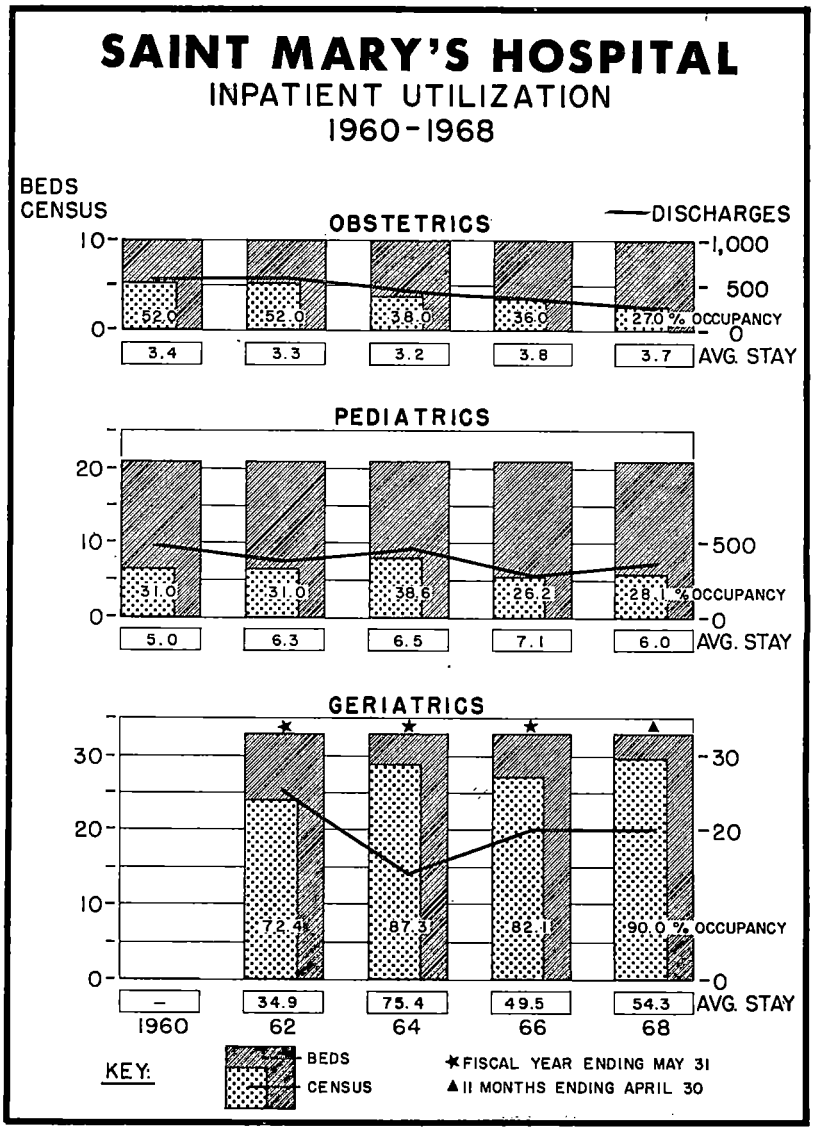


Exhibit No. 20—Continued

CHART - 7

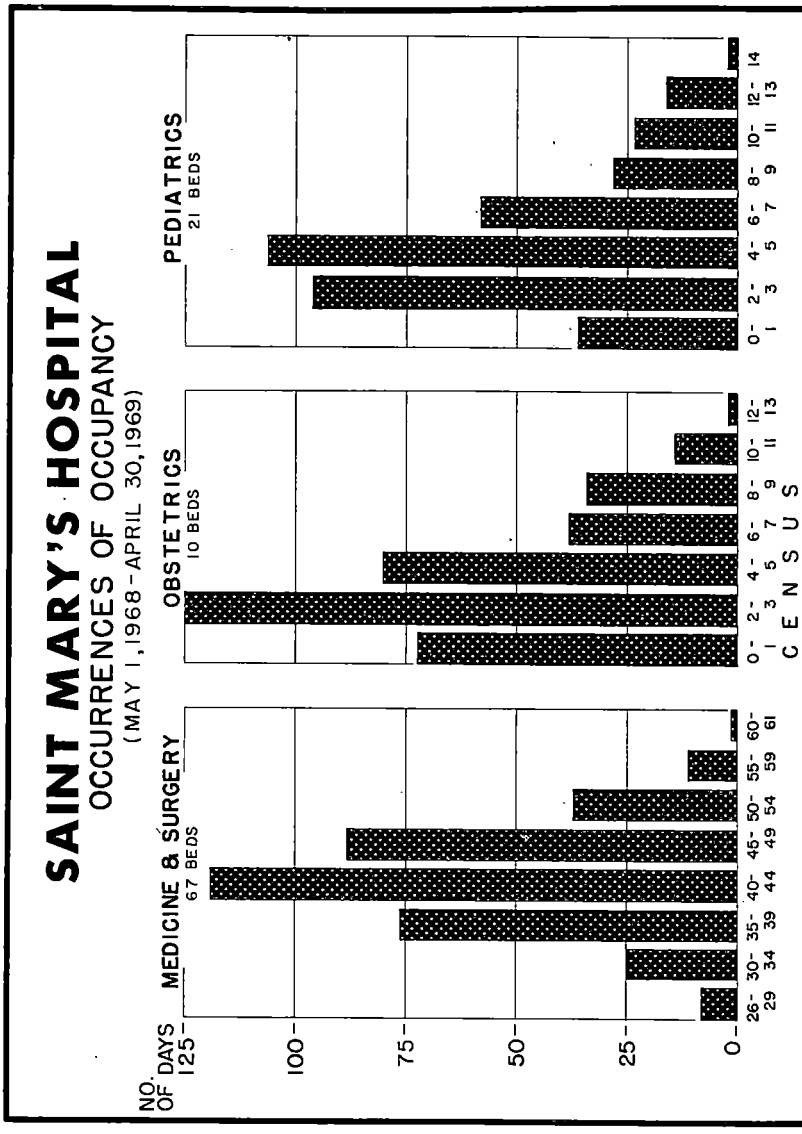


Exhibit No. 20—Continued

CHART-8

SAINT MARY'S HOSPITAL

COMPARISON OF LOCAL AND NATIONAL ADMISSION RATES 1960-1968

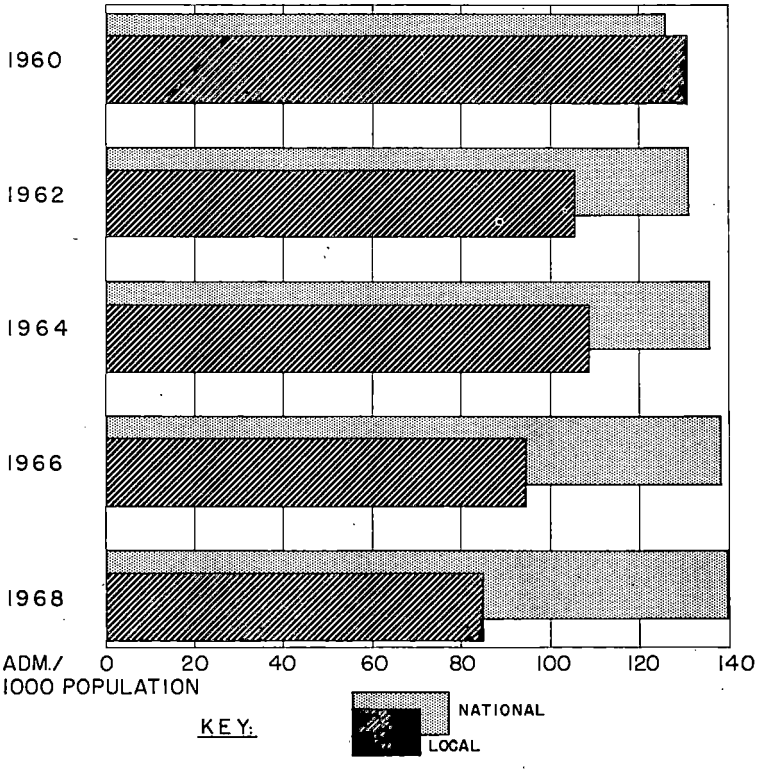


Exhibit No. 20—Continued

CHART- 9

SAINT MARY'S HOSPITAL

ACUTE CARE BED NEEDS
1970-1985

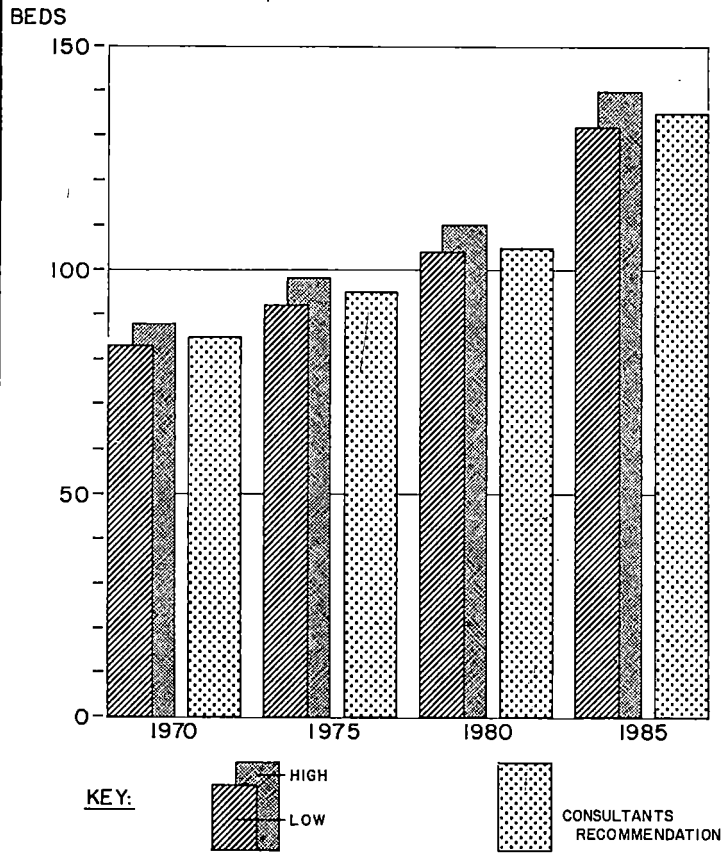


Exhibit No. 20—Continued

CHART 10

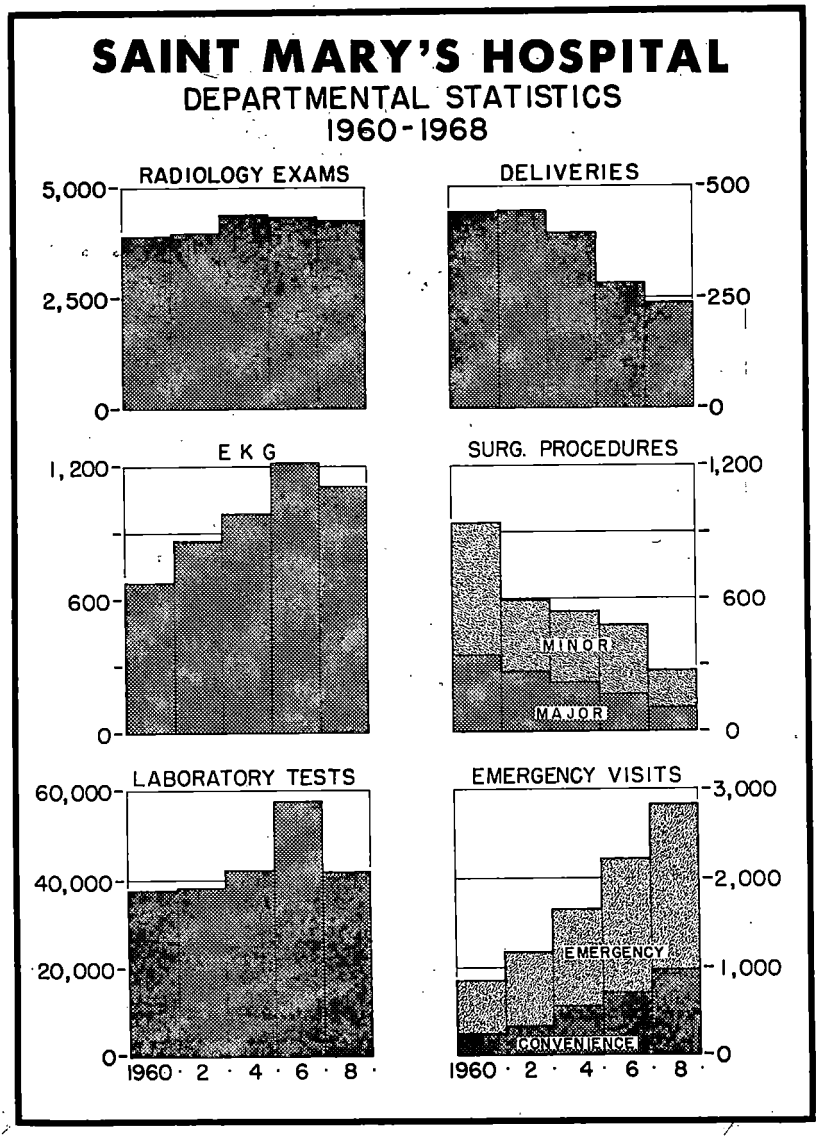


Exhibit No. 20—Continued

CHART-II

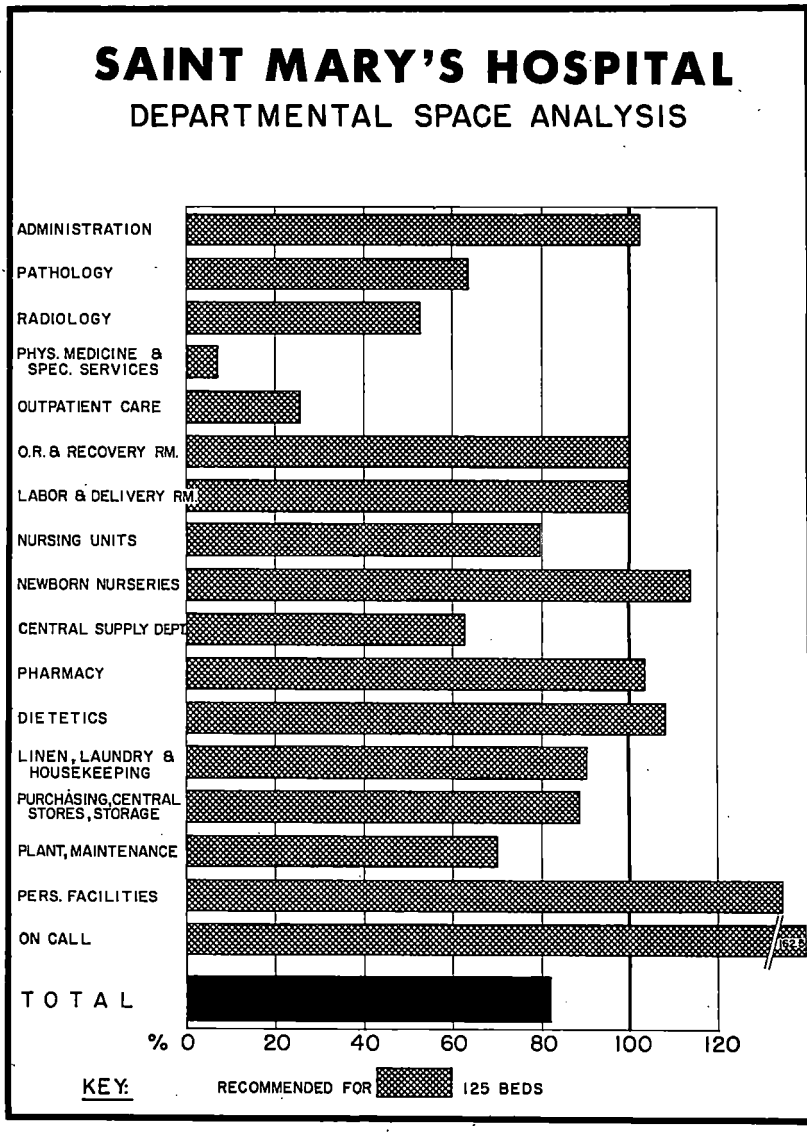


Exhibit No. 20—Continued

EXHIBITS

Exhibit No. 20—Continued

EXHIBIT- I

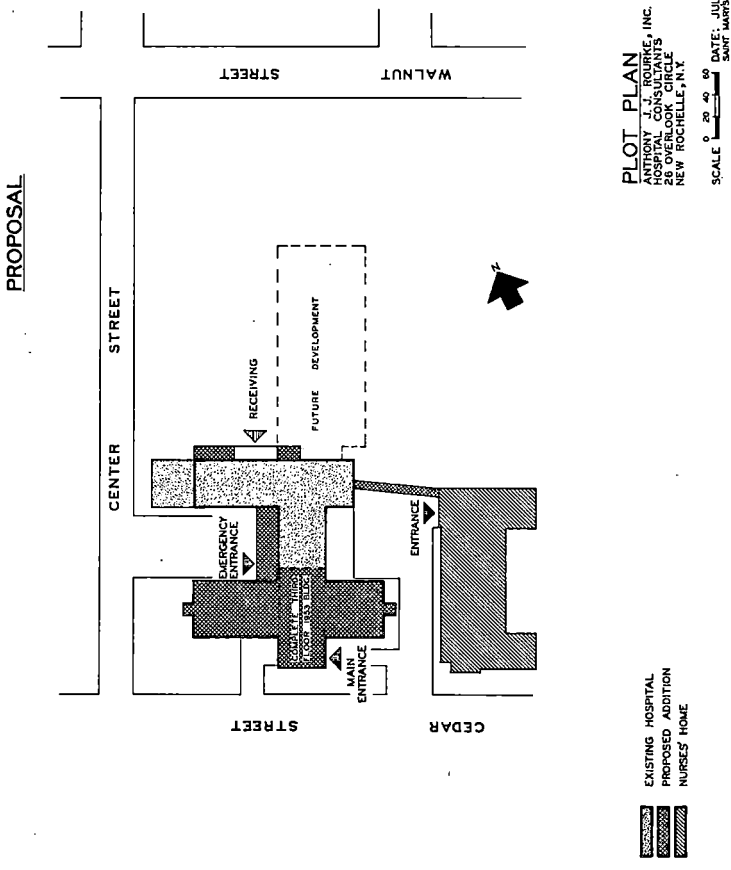


Exhibit No. 20—Continued

EXHIBIT- 2

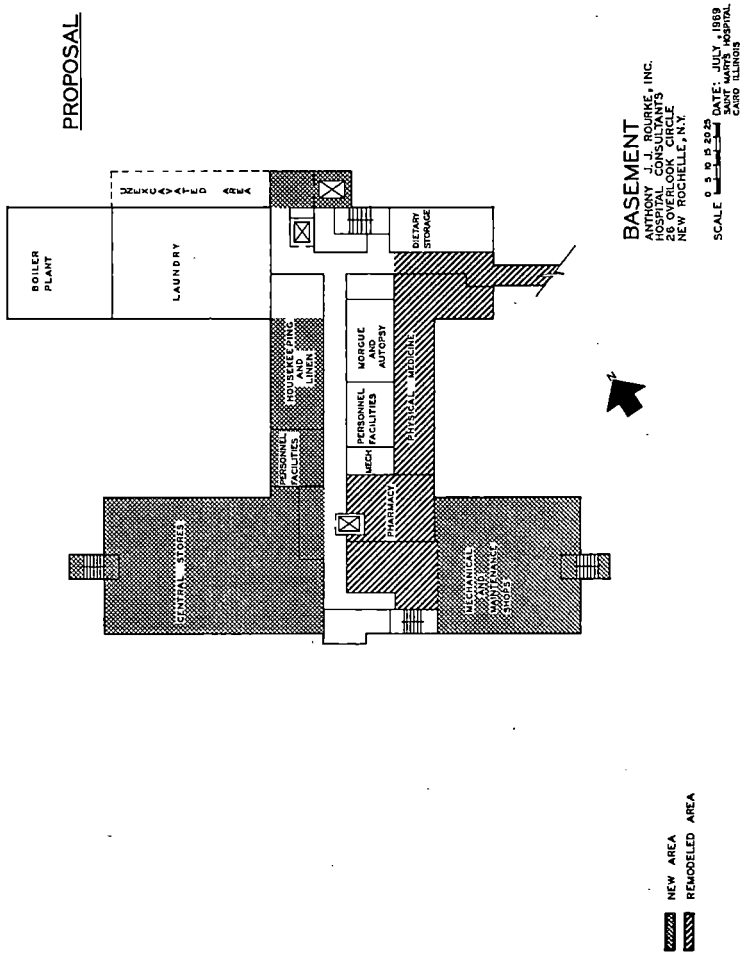


Exhibit No. 20—Continued

EXHIBIT- 3

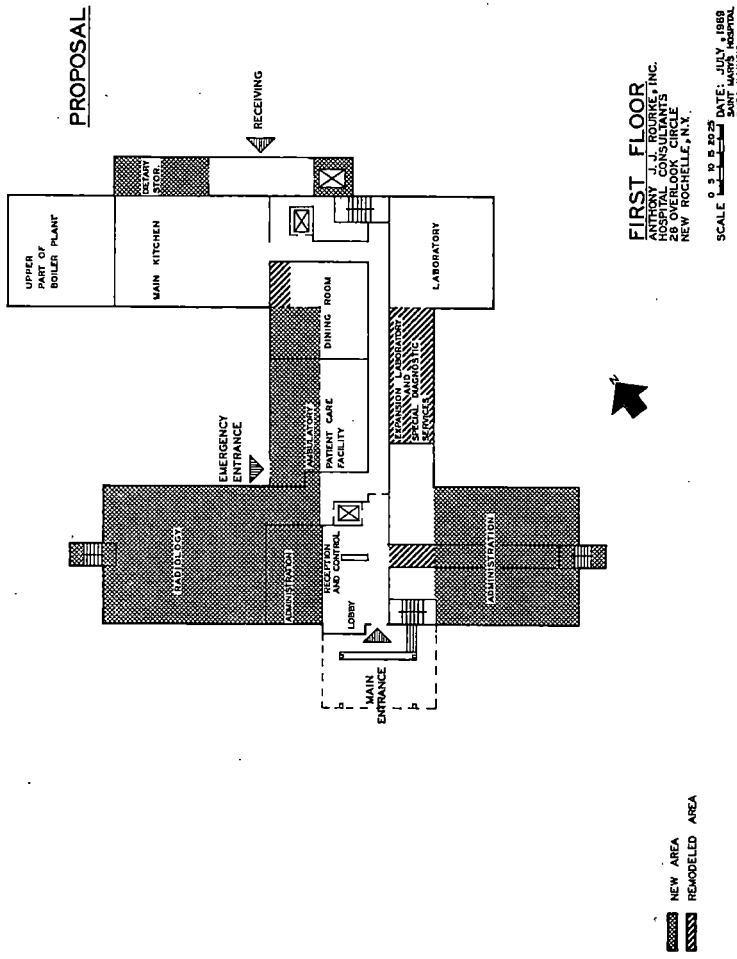
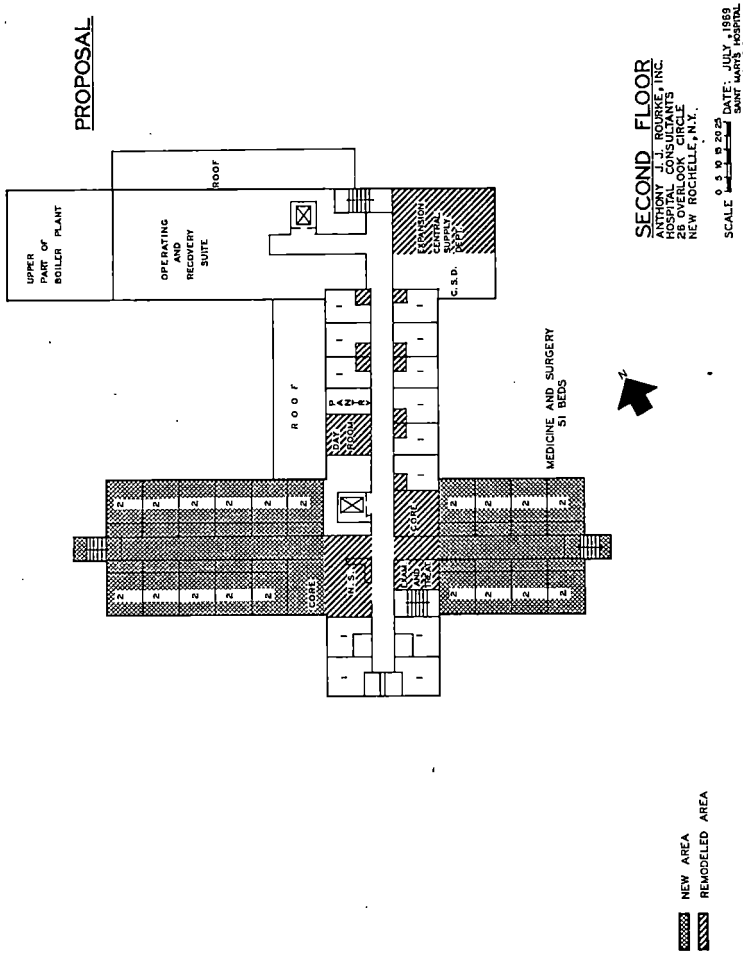
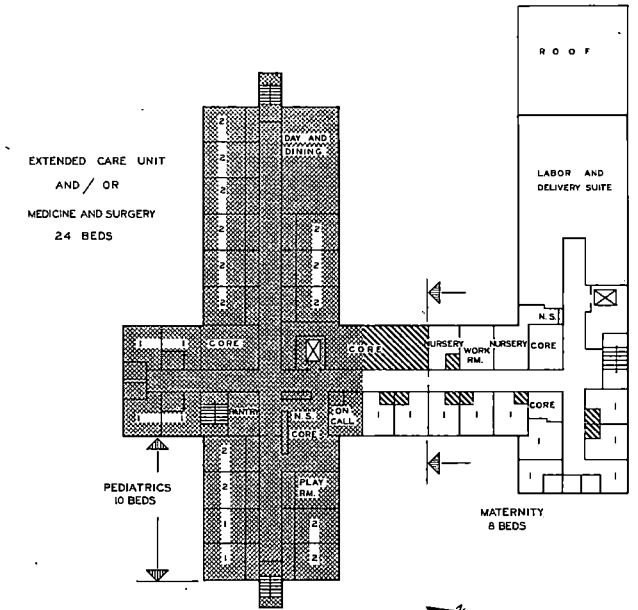


Exhibit No. 20—Continued

EXHIBIT- 4



PROPOSAL



NEW AREA
REMODELED AREA

THIRD FLOOR

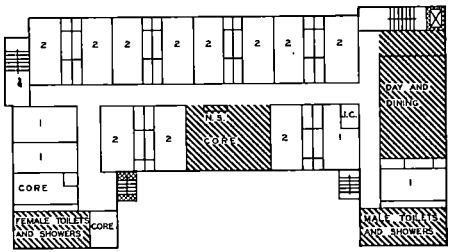
ANTHONY J. J. ROURKE, INC.
HOSPITAL CONSULTANTS
26 OVERLOOK CIRCLE
NEW ROCHELLE, N.Y.

SCALE 0 5 10 15 20 25 DATE: JULY, 1969

SAINT MARY'S HOSPITAL
CAIRO ILLINOIS

Exhibit No. 20—Continued

PROPOSAL



NURSES' HOME

NEW AREA
REMODELED AREA

SECOND FLOOR
ANTHONY J. J. ROURKE, INC.
HOSPITAL CONSULTANTS
26 OVERLOOK CIRCLE
NEW ROCHELLE, N.Y.

SCALE 0 5 10 15 20 25
DATE: JULY, 1969
SAINT MARYS HOSPITAL - NURSES HOME
CAIRO ILLINOIS

EXHIBIT-6

Exhibit No. 21

Farm Families

SAINT MARY'S COMMUNITY CLINIC;
CAIRO, ILLINOIS

FEE SCHEDULE FOR PATIENTS APPLYING FOR OEO ASSISTANCE FOR MEDICAL CARE.

Based on OEO poverty subsistance level of $1,000 annually for an individual of $3,400 for family of four. Declaration of patient on salary status in the initial interview clinic rating is determined.

If a patient is on Medicare and falls in the areas that qualify for assistance under OEO.....the clinic rating would be for Medications only.

If the patients are under other forms of Public Assistance, DPA, GA, etc., then they do not qualify for assistance under OEO. The proper agency will be billed for their care.

Yearly Income	Monthly	1	2	3	4	5	6	7	8	9	10	11	12	13
$8,000	$666.66													F
7,500	625.00												F	
7,000	583.33											F		
6,500	541.66										F			
6,000	500.00									F				
5,500	458.33								F					
5,000	416.66							F						
4,500	375.00						F							
4,000	333.33					F								
3,400	283.33				F									
2,800	233.33			F										
2,100	175.00		F											
1,700	141.66	F												

Legend;

Clinic Rating	Coverage with OEO Monies
F	Full (Outpatient Coverage)
DPA or GA	None
M + O (medicare + OEO)	Medication Only
M + DPA or GA	None

If the salary falls close to the next salary scale, then OEO funds will cover ALL EXCEPT MEDICATIONS. This rating will not be for business office use..... only for medications orders from outside pharmacies.

Exhibit No. 21—Continued

Non-farm Family

SAINT MARY'S COMMUNITY CLINIC;
CAIRO, ILLINOIS

FEE SCHEDULE FOR PATIENTS APPLYING FOR OEO ASSISTANCE FOR MEDICAL CARE.

Based on OEO poverty subsistance level of $2,000 annually for an individual of $4,000 for family of four. Declaration of patient on salary status in the initial interview clinic rating is determined.

If a patient is on Medicare and falls in the areas that qualify for assistance under OEO.....the clinic rating would be for Medications only.

If the patients are under other forms of Public Assistance, DPA, GA, etc, then they do not qualify for assistance under OEO. The proper agency will be billed for their care.

Yearly Income	Monthly	1	2	3	4	5	6	7	8	9	10	11	12	13
$9,500	$791.66													F
8,900	741.66												F	
8,300	691.66											F		
7,700	646.66										F			
7,100	591.66									F				
6,500	541.66								F					
5,900	491.66							F						
5,300	441.66						F							
4,700	391.66					F								
4,000	333.33				F									
3,300	275.00			F										
2,600	216.66		F											
2,000	166.66	F												

Legend:

Clinic-Rating	Coverage with OEO Monies
F	Full (Outpatient Coverage)
DPA or GA	None
M + O (medicare + OEO)	Medication Only
M + DPA or GA	None

If the salary falls close to the next salary scale, then OEO funds will cover ALL EXCEPT MEDICATIONS. This rating will not be for business office use..... only for medications ordered from outside pharmacies.

Exhibit No. 21—Continued

FINANCIAL REPORT

JULY 1971 - FEBRUARY 1972

TOTAL PERSONNEL		$33,384.51
Physician	$23,200.00	
Nurses and Others	10,184.51	
TOTAL OTHER COSTS		$13,227.73
Supplies	$1,172.59	
Equipment	1,000.00	
Pharmacy	4,492.80	
X-Ray	4,046.00	
Lab. Tests	985.00	
EKG	650.00	
Medicines - Clinic	232.40	
Travel & Maintenance	248.94	
Gas & Oil	400.00	
TOTAL EXPENDITURES		$46,612.24

Exhibit No. 21—Continued

SAINT MARY'S COMMUNITY CLINIC
STATISTICAL REPORT
JANUARY 4, 1971 - FEBRUARY 29, 1972

MAIN CLINIC

Total Patients Seen	1,892
Total Patient Visits	5,376
Children Under 14 yrs.	367
Black Patients	963
White Patients	929

OUTREACH

Total Patients Seen	420
Black Patients	289
White Patients	131
Total Patient Visits	1,438
Pyramid Court	296
Elmwood Place	287
High Rise	410
Unity-Sandusky	445
Total Mobile Unit Visits	593
Home Visiting	778

Exhibit No. 21—Continued

Home visiting has been done in following areas:
- Pyramid Court
- Elmwood
- High Rise
- Unity-Sandusky
- Future City
- Tamms
- Mounds
- Mound City

Follow-up care:
- Vital signs
- Injections
- Mother-Baby checkup
- Health teaching (diabetic instructions particularly)
- Post surgery checkups
- Emotional support
- Distribution of health literature (cancer, diabetes, etc.)
- Health movies and slides
- Make appointments
- Provide transportation
- Make sure patients are taking their medicine, taking them correctly, and have sufficient supply
- Make referrals

Referrals made through Outreach

Examples of referrals made include following:
- To Children and Family Services for hyperactive child
- To Neurology Clinic for seizures and abnormal gait
- To Mental Health Clinic for family problems requiring professional help
- To Emergency Room for foreign object of ear
- To Pre and Post Natal Clinic
- To physician for:
  - Hypertension
  - Lesion of mouth
  - Unhealing leg ulcer; foot ulcer in diabetic
  - Breast tumor; for breast bleeding in patient with previous surgery for cancer

*Exhibit No. 21—Continued**

* Ernst & Ernst financial report on St. Mary's Hospital is on file at the Commission.

Exhibit No. 22

HEW, Financial Assistance by Geographic Area, Fiscal Year 1971, Illinois, is on file at the Commission.

Exhibit No. 22—Continued

Frank Ellis, M.D.
Regional Health Director

February 11, 1972

Gerald Bennett
Assistant to the Regional Director
for Illinois and Minnesota

Cairo, Illinois

A "command performance" will make it unable for me to present my information on Cairo to the HSMHA staff meeting as you suggested. Because of my interest in the Cairo problem and the likelihood of future conflicts making it impossible for me to meet with you and your staff, I thought it would be superior approach to write down my information on Cairo in the form of a memorandum and let you act on the situation as you think best.

A Brief History

Several years ago, in reaction to the extreme polarization of Cairo's black and white communities, and in the belief that uncoordinated federal support of either of the polarized factions could exacerbate rather than improve the tense situation, the Federal Regional Council made a decision to fund projects in Cairo only after review by a Regional Council Cairo Task Force, and only after assurance had been given that the project would be administered or advised by a bi-racial advisory committee representative of a broad spectrum of community sentiment.

The mayor at the time was requested to establish such a committee for the town, but was unable to do so. The current mayor is unlikely to succeed where the former mayor failed.

The resultant situation is ~~that~~ there is a total of only ~~$15,018~~ 22,759 per year of Department of Health, Education, and Welfare funds being allocated for services in Cairo (according to Federal Assistance by Geographic Areas: ~~$15,018~~ 22,759 HSMHA Patient Care and Special Health Services), excluding, of course, trust fund outlays and formula funds administered by the Illinois Department of Vocational Rehabilitation,, Illinois Department of Public Aid, etc., on a county basis.

Exhibit No. 22—Continued

Cairo, Illinois - Page 2

Given the wisdom of insisting on involvement of a bi-racial advisory board, and the likelihood that no citywide committee will be established in the near future;

1. projects starting in Cairo should tie into whatever viable and well-balanced bi-racial committees exist, and

2. HEW should try to strengthen these foci of racial cooperation through funding and programmatic support.

My Visit

I didn't visit Cairo with the intention of finding project ideas, I went to Cairo to get some general data about the town and its problems and to meet a wide range of people, from whom I wanted to select a few to use as my contacts in Cairo when the need arose.

I spoke with a broad spectrum of people in town, ranging from the Administrator of the Cairo United Front to a leader of the White Citizens Council (UCCA) and including the newspaper publisher, news editor, chief counsel of the Lawyers Committee for Civil Rights under Law, Mayor, Development director of the local economic development agency and other prominent black and white leaders.

Everyone disagreed with just about everyone else on just about all issues, with the sole significant exception being the value of St. Mary's Hospital and its clinic. Although the white right wing disagreed, everyone else agreed that the Hospital and Clinic was the brightest hope in town. Even the representatives of the United Front, who harbor some resentments stemming from the hospital's whites only policy of years past, agreed that the hospital, and especially the clinic, is a progressive and effective force in providing services on a "color blind" basis, and in providing the nucleus for greater racial cooperation in dealing with the problems of Cairo.

I met with the administrator of the clinic (also, at the time serving as acting administrator of the hospital) and was highly impressed with her sensitivity and commitment. She has been in Cairo about a year, previously having worked with a United Farm Workers health project in Fresno, California.

Exhibit No. 22—Continued

Cairo, Illinois - Page 3

The Cairo clinic is currently being supported with OEO funds. This support ($100,000 for FY-72) will probably end after this year due to a lack of OEO funds. If OEO cannot continue, or if replacement funds cannot be found, the clinic will either close or else curtail its activities severely.

The hospital has applied for an HMO development grant, but has been turned down due to the review committee's assessment that the severe poverty of the area (55.6% of the households in Alexander County have cash income of less than $5,000 per year) would make it impossible to develop a viable HMO.

Another initiative of the clinic was to apply, through the Illinois Governor's Office of Human Resources, for support of a dental services clinic in Cairo. There are two dentists now in Cairo, and neither will treat public assistance (and, reportedly, black) patients. The dental proposal, which asks for $50,000 to support one dentist and supportive personnel and services, would go beyond "pulling and filling" to include dental education, preventive dentistry, etc. GOHR was unable to find state funding and transmitted the request on to us. I've had no luck so far either. (The clinic would probably be more than satisified with a National Health Service Corps dentist and about $20,000 for supportive activities.)

I don't know what, if anything, HEW could (or even should) do in response to any of these issues. In terms of non-technical (non-health related) aspects of the situation, I feel strongly that the health area, through St. Mary's Hospital and the clinic, is the best, if not only, entry point for a federal effort to support balanced progress toward bi-racial understanding and cooperation in Cairo.

Exhibit No. 23

MRS. CHARLES L. HUCKLEBERRY
2400 WALNUT STREET
CAIRO, ILLINOIS 62914

March 24, 1972

U.S. Civil Rights Commission, Subcomittee
Federal Building
Cairo, Illinois

This letter is in reference to your investigation of the availability of decent housing in Cairo. Not brought out in your hearing is the fact that Farm Home Administration, an agency of the Department of Agriculture is now providing funds for homes of low income families in this area. This is similiar to 235 and 236 H.U.D.

We have a house that is available, and while certainly not elaborate, is comfortable for our family with three children. This house is two stories; four bedrooms and bath on upper floor; - large entrance hall; living room with fireplace and carpeting; carpeted dining room; modern kitchen with adequate cabinets, built in range top and oven, disposal; - and a half bath on main floor; - full basement. Also included are air conditioners and curtains throughout. This house is in good repair; no remodeling is necessary; ready for occupancy as soon as we can move out. Price $8500.

Mr. Calvin Bof, (Black), who lives in Pyramid Courts has been trying to obtain a loan from the Farm Home Administration for the purchase of our home.

Exhibit No. 23—Continued

Both my husband and I have visited at the Farm Home Administration office on Thursdays, when a representative from Anna is here, to find out what progress is being made in granting this loan. Although this loan has not as yet been actually turned down, the representative was certainly not encouraging. The representative stated that his agency would rather provide funds for building a new three-bedroom home and that older two-story homes are seldom approved.

Now, my question is this: Is this agency of the U.S. Department of Agriculture really interested in providing decent housing that a low income family can afford - or is it merely trying to make a show by loading them down with a show place that will be a burden for years for a low income family.

There are homes available now and at prices that low income black or white families could afford.

Yours truly,
Marian Huckleberry
Carol L. Huckleberry

Exhibit No. 23—Continued

March, 24, 1972
Cairo, Illinois
Zip Code [illegible]914

[illegible] to the U.S. Commission on Civil Rights,

Dear Chairman [illegible] Maurice B. Mitchell,

I like to [illegible] you and Attorney Frankie M. Freeman, and others the [illegible] about Cairo, Ill. that might not be told [illegible] the [illegible] hearing here Thursday March 23, 19[illegible] 1:30 – 1:45 P.M. [illegible] paper giving a demograph[illegible] of Cairo. Our town needs a rebirth [illegible] in so many ways, its needs to be [illegible] again. The as tax payers, feel that the officials of the city own up of lots [illegible] start by cleaning the town up of with torn down shacks on them, let grass [illegible] there, fill the lots in with dirt. No industry will come to a town that looks like its dieing.

as for the economic and social picture of the area, Economic its in a pretty bad shape and social picture of the area, reforming [illegible] is needed real bad. 1:30 1:45 P.M. Residents giving [illegible] a detail picture of past events, what the future bring

as for the past we cover some ground, from its in housing fair treatment in Public Places, where you have to Eat & Sleep, the places thats open to the whole Public. In the past you didn't have much protection as you do now, if you were to get in jail here.

("Over")

Exhibit No. 23—Continued

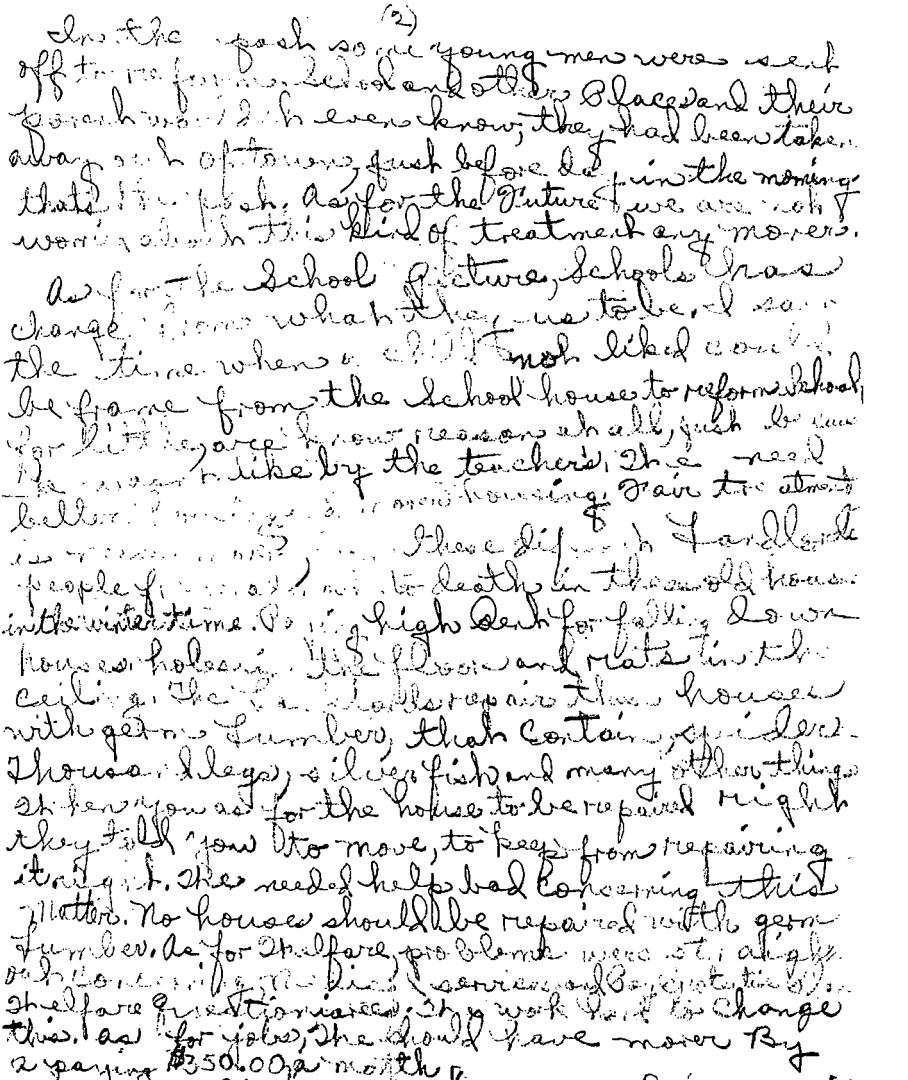


Exhibit No. 23—Continued

CAIRO, AN OUTSIDER'S VIEW

JEANNE KENNARD KLEINBERG
331 28TH STREET
CAIRO, ILLINOIS
62914
MARCH 24,1972
SS#214 26 4687

THE CIVIL RIGHT'S COMMISSION

Dear Mrs. Freeman and Gentlemen:
i have lived in Cairo since February 5,1972, so you see, i am definitely an out sider. i fell in love with this town when we came through here with a real estate dealer last summer, Since my husband is planning to retire, he bought me a house and we rented it to a clergyman until his own house became available.

Since I had planned to come to Cairo in the spring, it seemed more advisable to come here when the house was vacated rather than look for another tenant.

i am not a devoted, dedicated housekeeper and my real happiness lies in walking around the streets , talking to people. people really talk to me and I wish I could put this talent to some good, perhap s paying use.
I rezlly like people and they respond to me.

Now to come to the point. As you know, one is not supposed to make generaliz ation s from specific incidences, but with my lack of experience here, that is all i have to go on. Everybody, of both races, seems to tell me about our TROUBLE. it sems as if they are telling me about the skeleton in the family closet before someme else tells me. Everybody seems to regret it.

i spend a lot of time on the street and i would like to relate some of my experiences with the Children in Cairo.

i live on the predominately Black side of town. One day a ten year old boy asked"You move here?""Yes, is that good or bad?""Good, we need people in Cairo." This was a balck child. Days later when I asked how he knew we needed people he said he had heard it at home and in school. i learned, yupon questioning him that his mother is connected with the library in the school system.

Another incident with two black boys, about ten and twelve. I was in a supermarket in line and looking around to see if there wasanything I wqnted before I left. I did not notice that the woman in-fron of me had moved forward and that a black boy had gotten between us. it was only when I heard another boy say, as he was pulling him out of line, t"That lady was here first."

In Cairo, most people seem to say helle as they pass on the streets. The black boys and girls for the most part seem warm and fried friendly with a kind of childish innocence as if they haven't been disillusioned yet.

i wont say much about the Camelot children, i haven't had much contact with them and I am sure they will survive, either here or elsewhere.

One Sunday afternoon, on the nicer side of town(nicer as far as housing goes) i met a student from Bennett School who told me he hopes to be the president of the Ford motor Company , someday.This waas a white boy.

WHAT REALLY WORRIES ME IS THE POOR WHITE CHILD WHO HASN'T BEEN MENTIONED IN THE

Exhibit No. 23—Continued

CAIRO*PUTSIDERS VIEW

HEARINGS. The same day I saw the future Ford president, I was walking near some projects and saw two white girls about eleven years old who were unwrapping candy bars and throwing the paper on the ground.

I asked them why they were making their town ugly and one replied, Because I don t lak(sic) this town." "Why not?" "Ain't nothing in it." and they walked away.

This is the kind of child I worry about because she doesn't have association with Camelot children and she doesn't have association with black vhildren, either.

I may be wrong. Maybe the black people are putting on an act for my benefit when they see me." but they come accross b very warm and friendly.
I have an idea that the black children may be poor in a material sense but that they are very rich in having a warm, loving community in which to live.
i think that if I had to be very poor, in Cairo, I would prefer to be a poor black child.
Perhaps I am seeing the Black community through rose colored glasses because i have recently worked as the only Caucasian Aide in a nursing home in Baltimore and because I had black supervisors who were particularly warm and helpful and understanding. (EDGEWOOD NURSING HOME, BALTIMORE, MARYLAND21212)

you may wonder if anything troubles me about race relations in Cairo. Yes, I am afraid of one thing.White backash backlash. The law says that you must sell or rent to qualified people without regard to ethnic background. i am planning to buy a house in a predominately white area of Cairo. i know what the law says, it is the mores that worry me. As one of the witnesses said, "White people are afraid to work with blacks for fear of retaliation from other whites.
I think this is the MAJOR SOURCE OF DIFFICULTY IN RACE RELATIONS.

HOW DO I PROPOSE TO OVERCOME THIS DIFFICULTY?
i think the best way to overcome the fear of associating with people is or for authority figures to set the example.

If the authority figure in the country and in neighborhoods would set the example of associatig with people of different ethcnic groups, the other people in the country would have no difficulty in following . For example: If the PRESIDENT OF THE UNITED STATES would invite non whit s to his private home for social reasons, and other authority figurex would do so, it wouldn8t take on long to break down barriers in the country. I am not hereby advocating miscegenation, I think that is a private matter but if Authority Figures Really want to do something in this country, they should set the example so the reast of us could follow withoub fear of retaliation from our ethnic group.

In Baltimore, ewhen a group of merchants wanted to do something about tearing down our old buildings and building new ones, they didn8t get anywhere until they invited a man who was a socially prominant millionaire(Clarence Miles) to help them. Perhaps the approach in Cairo should be that the United States government should invite the socially prominant white people to give an inch and "help" the government. If the government approaches the most prominant people in town to help, how can they refuse the government. Give them a fancy title-make a "fuss" over them and give them publicity both in Cairo and nationally. if the ESTABLISH* MENT is cajolled into being helpful, the ordinary person won t find it hard at all. think what I am saying is this, if the white establishment could enhance its prestige by woring on race relations as a favor to the US government, it couldngt reefuse and things would get better. The ordinary person could be persuaded to think that his social value was enhanced by working on bi-raacial committees.

Exhibit No. 23—Continued

CAIRO *OUTSIDERS VIEW KLEINBERG

When my husband bought me this house, he challenged me to do somthing about Cairo. I don't know if he is teasing me or if he really thinks I can do it. He challenged me to bring industry here. I haven't any training for that. In fact I haven't any training for anything , , failed every thing I ever tried. The only asset I have is a rather big mouth and a fairly persuasive manner. /And, as I told you, people talk to me. It takes all my time and I am supposed to be doing housework, but I would rather listen to people.

I haven't any skills as far as hand and eye coordination and manual dexterity are d cioncerned-just the ability to listen.

If the government would talk the white ESTABLISHMENT into being helpful, I really think I could talk the rezst of the people into cooperating. I think the balck people are loving and willing enough to cooperate, there are some very i ntellig intelligent and helpful black women in this area-business professional types but they need the whites to work with them. I would love to work-with them if I thought I could do it without getting hurs hurt by the whites. I realize I am a coward but then, good guys get ~~assinated~~. ASSASSINATED assassinated

i think that if you can get the ESTABLISHMENT to work for you and with you, the others will follow especially if the newspaper will cooperate and give Mrs MRS. NONAME some publicity because she is working on the COMMITTEE with MRS. PROMINANT BLACK AND MRS, WELLKNOWN WHITE.

Before I left Baltimore, i was talking to MRS. THELMA W, HILL on the telephone. She told me about INSTITUTIONAL RACISM-this is where institutions such as our most prominant newspaper in town said they had more important things to print tha n the engagement of negro girls. If we are going to deplore illig- imacy among negroes, wy why dont we publicize the engagement of a girl who is getting married in a socially acceptable manner?
Maybe we can't supply jobs for black people in Cairo but at least they can be given appropriate publicity when they have don~ somt something. worhwhile.

I don't reccommend ggiving publicity to young girls of either race , if they are very young because sometimes sick people lure the girls as a result of it. This happened in Baltimore in September.or somstime before Christmas, I am not sure .

I am living in Cairo alone until my husband retires. He told me not to talk about RACE ro anyone. That is all anybody in this town talks about. They want help but don t know how to go about it. I think the people here really like each other . I don t really think there is hatred between the races . i think the real problem lies in the white man's idea that he will lose prestige or ; might be hurt by other whites if he associates with nonwhites, If you can overcome this feeling on the part of whites, it won t sol v everything but it will certainly help. If you could get NATIONALLY PROMINANT WHITES and LOCALLY PROMINANT WHITES / r to work in this field of race relations, i think the whoe country, and the local areas would be helped immensely.it would really help if the FEDERALGOVERNMENT could make work in race relations a STATUS ACTIVITY giving prestige etc. Maybe we need another Eleanor Roosevelt.

In case you are wondering about me, my early heroines were Jane Addams, Louisa Mae Alcott and Eleanor Roosevelt. i am a Marylander, My family has been in Maryland since 1640.. Although I am not exactly a WASP. my orientation is WASP and my husband is Jewish, from the lower east side of new York. I might add that all of my cousins, however, are Roman Catholic.

I am not saying this is how things AREin Cairo. This is how they SEEM to me.
THANK YOU FOR COMING TO CAIOR CAIRO. JEANNE KLEINBERG

Exhibit No. 23—Continued

MISCELLANEOUS COMMENTS ON CAIRO
AN OUTSIDER'S VIEW

JEANNE KLEINBERG
331 28TH STREET
CAIRO, ILL.
62914
SS#214 26 4687

MRS, FREEMAN AND GENTLEMEN:

While i am not exactly sure if these comments come under the hezad of CIVIL RIGHTS YOU MAY BE INTERESTED IN THEM IN RELATION TO THIS CITY,
Cairo is referred to as as a city but to ,me, it is so small that i can walk from one end to the other in a few hours. my own reaction to it is that it is a neighborhood andI feel that way in relation to its residents.

i walk through areas in Cairo that are so dilapidated that I would not consider walking through a similar area in altimore. i do not feel afraid in the predominantly black areas of airo even though i am aware that i am under surveillance at all times by the community. The TAMALE MAN told me one day, " saw you by the hospital yesterday." evertheless, except for the fact that I have been advised by black women not to walk around Pyramid ourt, i do not feel thatCairo people would harm me.

Mr. Powell seems disturbed that there are no black men participating in various projects. i told him that there are hardly any black men in this area who are between the ages of 20 and 60. this is pretty much true of white men too. There are some business men who are running businesses that were started by their grandfathers. Except for white and black high school youths, if you have been able to observe the men who came to the Court for reasons of testimony or as spectators, you hava seen just about all the able bodied men in Cairo. There is a song from World War IIthat says, "They're either too young or too old." This is true of the men who live in Cairo. would suggest to Mr. Powell that there are probably some educated black women in Cairo and perhaps, in some areas they could represent the black community.

I don't know if CIVIL RIGHTS would be involved, but there is a great deal of trash and debris in Cairo, partivularly between the areas of Sycamore to Commercial Streets. This debris consists of old tin cans, bottles broken glass old car parts and things that are hard to get rid of. Even if the neighbors were to gather up this junk, how would they be able to get rid of it? it occurs to me that rats might find good homes in all of this debris.

I suspect that my personal dilemma about renting the house might be solved if I move into the new one and offer the old one for rentbecause it is in a mixed area.That, however, is not really a solution. eople have to see each other as human beings and be accepting of one another.

i regret the action of young men who bought violence to the city because they only served to convince people that the most biased element of white society is right . they really made it difficult for anyone who would be willing to work together as neighbors.
Cairo is so very small, it ought to be very easy to get the people to work well together. erhaps we need a little handholding by the government because we are not trained in the techniques that would bring people together. It must be done so that nobody loses face by participating.

Exhibit No. 23—Continued

I know it would be too much to ask the government to put some kind of Federal installation here because Cairo is too small but if there were one or in a nearby area, it would bring younger people here to live,if we could overcome the unfavorable publicity.

I am really in love with Cairo. I don't think it is hopeless. We just need a little leadership.

I suppose I see my own role in this town as a kind of catalyst even though I don't have any training for it. I think I could make friends if I had a little help from UncleSam2. To me, Cairo is a very romantic place- a place where men send valentines to their wives. I know that I want to write about Cairo even though my efforts at writing have been limited to being editor of theIDLEWYLDE NEWSLETTER and THE TOWSON TIMES(a column) In neither case was I paid, but I enjoyed it anyway.

I would also like to inform you that all opinions are strictly my own. Since my husband is a government employee, I hope my ideas will not reflect unfavorably upon him in any way. he isn't in Cairo, yet.

AGAIN, THANK YOU FOR COMING TO CAIRO, JEANNE KLEINBERG

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